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ABSTRACT

The nature of the historical changes in the presumed stereo-types of drug users in the United States, and the associated policy changes, are described in this report which takes a community health viewpoint of drug use while concurrently dealing with the individual. Eight case histories illustrate the community mental health approach in action. Three of these cases are descriptions of programs for school staff, staff of a vocational rehabilitation service, and for hospital and community agency offices. The results of one research study using this approach and a bibliography are appended. A glossary of dependence producing drugs, classified according to their effect on the central nervous system, with brief descriptions of the legal regulation, form and effect of each class is also appended. (AL)

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A COMMUNITY MENTAL HEALTH APPROACH TO DRUG ADDICTION

SYSTEMIC ANALGESICS
NON-NARCOTIC ANALGESICS
SYNTHETIC OPIATES
phenacetin aspirin acetanilid
methadone anileridine meperidine
NATURAL OPIATES
morphine codeine opium heroin
NARCOTIC ANTAGONISTS
CNS DEPRESSANTS
nalorphine cyclazocine
BARBITURATES
pentobarbital phenobarbital secobarbital amobarbital
NON-BARBITURATE SEDATIVES
meprobamate paraldehyde chloral hydrate
ALCOHOL
CNS STIMULANTS
AMPHETAMINES
amphetamine methamphetamine dextroamphetamine
NICOTINE COCAINE CAFFEINE
PSYCHOTROPICS
TRANQUILIZERS
PHENOTHIAZINES
chloropromazine
RESERPATES
reserpine
ANTI-DEPRESSANTS
LSD
HALLUCINOGENS
psilocybin mescaline peyote
MARIJUANA

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A COMMUNITY MENTAL HEALTH APPROACH TO DRUG ADDICTION

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Alfred Freedman, M. D.

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Office of Juvenile Delinquency and Youth Development

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We are particularly grateful to the addicts themselves, whose continual effort to help themselves and others enabled us to gather the data for this manual.

Our final thanks are extended to the many professionals all over the world who have visited and trained with us. Our exchanges with them are reflected in this discussion. Any obvious errors are to be attributed to us, not to them.

RICHARD BROTMAN

ALFRED FREEDMAN

FOREWORD

Although drug addiction is a problem of mounting concern, knowledge about effective methods of prevention and control remains extremely limited.

Among those who have used innovative methods to learn more about the problem and to attempt to deal with it more effectively are the authors of this publication: Richard Brotman, Ph. D., a professor in the Department of Psychiatry and the director of the Division of Community Health of the New York Medical College, and Alfred Freedman, M.D., the chairman of the Department of Psychiatry of the New York Medical College.

The views, opinions, and conclusions are those of the authors and publication does *not* imply official endorsement by the Department of Health, Education, and Welfare. The document is issued by the Office of Juvenile Delinquency and Youth Development as part of a training program which includes providing curriculum materials that will stimulate provocative discussion in training courses. The report should also be of interest to members of the various professions who wish to keep informed about new developments in the broad field of juvenile delinquency prevention and control.

RALPH M. SUSMAN
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and Youth Development

CONTENTS

FOREWORD iii

I. THE AMERICAN REACTION TO NARCOTICS USE 1

II. PHYSICAL, PSYCHOLOGICAL, AND SOCIAL ASPECTS OF ADDICTION 8

III. THE COMMUNITY MENTAL HEALTH APPROACH TO DIAGNOSIS 15

IV. TARGETS, GOALS, AND METHODS FOR INTERVENTION 31

APPENDICES 41

A. Glossary of dependence producing drugs 43

B. Screening instrument 53

C. Case histories 83

D. A research study 117

E. Bibliography 135

I. THE AMERICAN REACTION TO NARCOTICS USE

BACKGROUND AND EARLY LEGAL POLICIES (1805–1925)

In order to be properly understood, the problem of drug addiction in the United States should first be viewed in an historical perspective.

In the 30 years following 1805, the year that morphine was discovered, several other alkaloid derivatives of opium, including codeine, were found. In the middle of the 19th century the hypodermic syringe was invented. Subsequently the injection of morphine and other narcotics to relieve pain—as well as the use of opiates in cough medicines, tonics, and patent medicines—became common, so common in fact that during the Civil War morphine addiction came to be called the "Army disease." Meanwhile, the smoking of opium for pleasure had been introduced by immigrants from China. Thus, by the end of the 19th century, the unregulated use of narcotics was beginning to be considered a serious problem, although doctors generally did not understand the mechanism of addiction.

In 1898 heroin, another alkaloid derivative of opium and morphine, and more potent than either, was isolated. It was thought to be nonaddictive, and thus was substituted for morphine in medicines and tonics. However, it soon became apparent that heroin was even more addicting than the narcotics it was meant to replace, a problem that has recurred more recently with the synthetic narcotics, meperidine (Demerol) and methadone (Dolophine).

By 1910 drug addiction was recognized as a potential social and legal problem, although its medical aspects were not fully understood. Popular estimates of the rate of addiction ranged from 1 to 4 percent of the population. Against a background of considerable concern and little scientific understanding, the U.S. participated in the 1912 Hague Opium Convention, called to establish international control of the production, sale, and use of narcotics. Then, in 1914 Congress passed what is still this country's basic narcotics law, the Harrison Act.

THE HARRISON ACT

The Harrison Act was a revenue measure, a part of the Internal Revenue Act, and administered by a branch of the Treasury Department (known since 1930 as the Federal Bureau of Narcotics). In *The Addict and the Law,* Alfred Lindesmith says of the Act:

> Its ostensible purpose appeared to be simply to make the entire process of drug distribution within the country a matter of record. The nominal excise tax (1 cent per ounce), the requirement that persons and firms handling drugs register and pay fees, all seemed designed to accomplish this purpose. There is no indication of a legislative intention to deny addicts access to legal drugs or to interfere in any way with medical practices in this area.[30]

In 1922, the Narcotic Drugs Import and Export Act was passed, and in 1924 the domestic manufacture of heroin was outlawed. Thus, heroin is in a sense uniquely illegal, since permission must be obtained from the Treasury Department to use it even for legitimate research purposes. In these cases imported heroin is used (it is legally manufactured and used in other Western countries). However, neither the Harrison Act, nor any other law, makes narcotics illegal in the sense that their use is simply forbidden.

The Harrison Act made no direct mention of addicts or addiction. It specifically exempted individuals who received narcotics from a registered physician, although it stated that the prescription had to be "for legitimate medicinal purposes" and "prescribed in good faith," and that the drugs had to be dispensed or distributed by a physician, dentist, or veterinary surgeon "in the course of his professional practice only." The Act did not make addiction illegal (a 1962 Supreme Court ruling held that a law which did so would be unconstitutional); [37] nor did it specifically either allow or forbid a doctor to give drugs to an addict regularly. But unfortunately the term "professional practice" was not defined, and thus it became the basis for 50 years of legal problems for the narcotic user, the doctor, and the community.

EARLY SUPREME COURT CASES

The first Supreme Court decision on a case of a doctor who had prescribed large quantities of narcotics to an addict occurred in the *Webb* case [46] of 1919. It was ruled that drugs prescribed indiscriminately for an addict "not in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use" did not fall within the exemption provision of the law. In the *Jin Fuey Moy* case [21] in 1920, the Court said that a doctor could not legitimately prescribe drugs "to cater to the appetite or satisfy the craving of one addicted to the use of the drug." But in 1922, the *Behrman* case [43] decision deemed such prescriptions illegal *regardless* of the doctor's purpose. This had the clear effect of depriving the addict of medically supervised treatment for his addiction, for it became legally impossible for a doctor to treat him with opiates in any way that was not likely to lead to prosecution. *The addict was forced to turn to illegal channels to obtain his drugs, and thus his dependence on the criminal world became established.*

THE LINDER CASE

Many doctors were in fact prosecuted and jailed in the early 1920's, and as a consequence most physicians ceased treating addicts at all—of the 8,100 physicians in New York City, less than 40 continued to prescribe narcotics for addicts.[35] However, in the *Behrman* case, the Court suggested that had the physician prescribed a smaller dose of narcotics, he might not have been subject to conviction. And in the 1925 *Linder* case [29] (Dr. Linder was accused of having sold a female addict with withdrawal symptoms one tablet of morphine and three tablets of cocaine for self-administration; she was an informer and he was arrested) the ruling stated that the Harrison Act

> says nothing of "addicts" and does not undertake to prescribe methods for their medical treatment. They are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith, four small tablets of morphine or cocaine for relief of conditions incident to addiction. What constitutes bona fide medical practice must be determined upon consideration of evidence and attending circumstances.

Further, the Court stated that

> the direct control of medical practice in the states is beyond the power of the Federal Government and that an incidental regulation of such practice by Congress through a taxing act cannot extend to matters plainly inappropriate and unnecessary to reasonable enforcement of a revenue measure.

Partially contradicting itself a year later by circumscribing "bona fide medical practice" in the *Boyd* case,[3] the Court said: "Regardless of whether the course of treatment given by the defendant is a cure, the question is was he honestly in good faith in the course of professional practice and in an effort to cure disease issuing these prescriptions."

Thus, despite the fact that the Supreme Court had recognized that addiction was a disease and proper subject for medical treatment, the physician could never know in advance whether he might be arrested and subjected to a "consideration of evidence and attending circumstances." The successful prosecution of so many doctors for a decade in the late teens and early twenties led them to realize that treating addicts entailed enormous professional risk—Dr. Linder's exoneration cost him $30,000 and his medical license for 2 years—and few private physicians were willing to expose themselves to that risk.

ARCOTICS CLINICS

Some attempt was made between 1919 and 1923 to deal with the fact that addicts existed and required treatment. There were virtually no in-patient hospital facilities available to the drug user. Hospitals began refusing to admit them altogether, due in part to the discouraging rate of "cure" and in part to some sensational publicity of episodes in which addicts had either bribed or forced hospital attendants to give them quantities of drugs. Consequently, 44 outpatient narcotic clinics were opened throughout the country.

In the report [41] of the Commissioner of Internal Revenue of June 30, 1919, this statement appears:

> It is evident from the enforcement of the law as amended that provision must be made for the treatment and cure of addicts who are *unable to obtain supplies of drugs necessary to* meet their proper needs, as the ordinary addict, when suddenly deprived of the drug to which he is addicted, suffers extremely both physically and mentally, and in this condition may become a menace to life and property.
>
> To meet immediate demands for the treatment of addicts, this matter has been taken up with State and municipal boards of health, and in many instances local clinics have been established to handle this situation temporarily.

But the report from the following year says:

> Steps are now being taken to close these clinics, which are not only a menace to society but a means of perpetuating addiction.

And by 1923 the last clinic, the one in Shreveport, La., was closed. All the others had ceased operation by the end of 1921 (the reason given for closing the Los Angeles Clinic in 1921 was that "it was the only one left in the U.S.").[35] Lindesmith [30] suggests that the Government's change of attitude toward the clinics between 1919 and 1920 may have been due to the fact that in December 1919 the revenue officers in charge of enforcing the Harrison Act were replaced with 12 supervising Federal prohibition agents who apparently brought with them the Volstead Act philosophy.

It is little wonder that the clinics failed to show spectacular results. They were initiated as an emergency measure; many were poorly planned; and most operated for only a few months, which did not allow time for routine technical problems to be worked out. But the claim of the Government, supposedly borne out by annual narcotics arrest figures, that the clinics spread addiction by making drugs easily available is insupportable. Prior to the Harrison Act, narcotics were available legally in drug and grocery stores; it was the law labeling the addict in possession of narcotics a criminal which led to more narcotics arrests—and the arrest rate continued to climb after the clinics had been closed.

Another powerful force working against the clinic approach was the opposition to the outpatient treatment of addicts voiced by the American Medical Association. In June 1921 a committee of the A.M.A. recommended that

> the American Medical Association urge both Federal and state governments to exert their full powers and authority to put an end to all manner of so-called ambulatory methods of treatment of narcotic drug addiction, whether practiced by the private physician or by the so-called "narcotic clinic" or dispensary.[13]

It must be kept in mind, however, that contemporary evaluations of the clinics were not uniformerly negative. In spite of the Treasury Department's contention, based primarily on the failure of the New York Clinic, that they were all disastrous failures, contradictory evidence is offered in *The Opium Problem*,[39] an authoritative and extensively documented book by Dr. Charles Terry and Mildred Pellens of the U.S. Public Health Service. The volume contains the medical reports of all the clinics, and it indicates, as Dr. Marie Nyswander, a noted New York psychiatrist specializing in the treatment of drug addiction, says, "If the clinics had been continued, addiction today would be a simple medical problem and not the complicated sociologic problem it has turned out to be." [19]

ADDICTION AND CRIMINALITY

Prior to the prosecution under the Harrison Act of physicians for medical treatment of addicts, and the prosecution of addicts themselves for possession of the narcotics they could no longer obtain legally, no systematic connection existed between addiction and criminality. Nevertheless, the prime rationale for the pursuit of addicts has been the stereotyped version of the addict-as-criminal. But "that addicts become what they are because of the way they are treated or that the size of the problem is connected with an inappropriate plan for dealing with it are ideas which apparently have not occurred to narcotics officials." [30] It is ironic that just at the time when addiction had begun to receive considerable medical, legal, and social attention in this country, the addict was pushed into a hitherto unnecessary association with the underworld—much to the addict's detriment and the underworld's profit—and his popular image and treatment have been strongly colored by that association ever since.

SUBSEQUENT ENFORCEMENT PRACTICE AND RECENT TREATMENT PROGRAMS (1925–65)

The Supreme Court has not heard a case bearing on the medical treatment of addicts since the 1925 *Linder* case which, as an interpretation of the Harrison Act, is still the controlling doctrine of the Federal courts. In 1936 Federal Judge L. R. Yankwich said in the case of *U.S.* vs. *Anthony:*

> I am satisfied therefore, that the *Linder* case, and the cases which interpret it, lay down the rule definitely that the statute does not say what drugs a physician may prescribe to an addict. Nor does it say the quantity which a physician may or may not prescribe. Nor does it regulate the frequency of prescription. Any attempt to so interpret the statute, by an administrative interpretation, whether that administrative interpretation be oral, in writing or by an officer or by a regulation of the department, would be not only contrary to the law, but would also make the law unconstitutional as being clearly a regulation of the practice of medicine.[42]

Nevertheless, a combination of causes—including the existence of the Treasury Department administrative regulations referred to above, the unwillingness of most reputable physicians to jeopardize their careers and financial status by becoming involved in complex legal matters, the reluctance of lower courts to challenge an enforcement policy which has the vigorous support of most of the police, some of the public, and a few doctors, and the apparent caution of the Government in prosecuting certain cases which might give the Supreme Court a chance to rule in this area—all these factors have worked in fact to bring about a situation in which courts still rule on the "good faith" of a physician (case by case, since no definition of good faith has ever been formulated in relation to treating addiction), and doctors of high reputation and professional ability continue to be prosecuted, without reference to the statements of medical experts whose opinions on the proper treatment of disease would in other circumstances be respected in defining "legitimate medical practice." [30]

FEDERAL NARCOTIC LEGISLATION

Although there has been no Federal judicial redefinition of the Harrison Act since 1925, there have been legislative amendments concerned with the imposition of harsher penalties for violations. The Harrison Act provided only for a maximum prison sentence of 10 years, the particular penalty to be determined by the judge before whom the case was tried. The Boggs Amendment of 1951 increased penalties to: (1) not less than 2 or more than 5 years, with probation permitted, for a first offense; (2) mandatory 5 to 10 years, probation and suspension of sentence excluded, for a second offense; (3) mandatory 10 to 20 years, probation and suspension excluded, for third and subsequent offenses.

In 1956 the Narcotic Drug Control Act increased penalties even further: (1) 2 to 10 years, with probation and parole permitted, for a first possession offense; (2) mandatory 5 to 10 years, probation and parole excluded, for a second possession or a first selling offense; (3) mandatory 10 to 40 years, probation and parole excluded, for a third possession or second selling and subsequent offenses; (4) 10 years to life with no probation or parole, or death if recommended by a jury, for sale of heroin to a person under 18 by a seller over 18.

The 1956 Act, in addition to imposing stricter penalties, eliminated parole for all except first possession offenders. This meant that the addict, unlike most other Federal prisoners, could not be paroled under supervision after serving one-third of his sentence. Of this provision, James V. Bennet said in 1962, when he was Director of the U.S. Bureau of Prisons:

> It is extremely difficult to get this group to participate in our rehabilitative program. That, of course, is due largely to the fact that we can provide no incentive for them. They are doing what in prison parlance is called "flat time"—a sentence without hope of parole or remission no matter how hard they may try to better themselves. The consequence is that when their discharge finally comes many leave little better than when they entered. In fact, some of them may be worse because whatever skills and industrial contacts they may have had have been lost.[36]

Before 1951 judges were able to impose sentences much longer than 10 years by stipulating that terms for multiple counts be served consecutively rather than concurrently. In this way, major narcotics dealers, for example, could be given sentences commensurate with their offense. At the same time, minor offenders could be given small sentences. As it stands now the imposition of very long Federal sentences on dealers is still possible, but the "diseased" addict convicted of possessing narcotics for the third time must also be given at least a 10 year sentence—and he may be sentenced to as much as 40 years—with no chance of parole. Of course, the idea that increasing the severity of penalties would reduce the number of offenders has proved false: 4 percent of the Federal prison population in 1946 were narcotics violators; in 1960 the figure had increased to 15 percent.

In a 1964 policy statement, "Narcotics Law Violations," the Advisory Council of Judges of the National Council on Crime and Delinquency said:

> Since the illegal handling of narcotic drugs today is a big business of organized crime, State and Federal law enforcement efforts should concentrate on reaching the criminals at the upper administrative level.
>
> *The addict should be directed to medical help and should not be criminally prosecuted.* While the Advisory Council of Judges recommends freedom of medical treatment for addicts, it recognizes the evil of the existing narcotics traffic and the need to prohibit it by penal laws. The problem is primarily one of law enforcement. Our experience coincides with that of other State and Federal judges: the "higher-ups" in the rackets are rarely brought before us for sentence. Rather, the great majority of narcotics law violators before us are addicts. Although a number of narcotic pushers are also convicted, the majority of them are primarily users also, whose addiction leads them to sell drugs in order to continue their own supply. These persons are more victims than criminals.
>
> To cope with the real traffickers in narcotics, State and Federal law enforcement efforts should be concentrated against all aspects of organized crime. Meanwhile, extending medical care to addicts and administering drugs as necessary would deprive organized crime of a constantly increasing percentage of its customers and would weaken the foundation of narcotics syndicates, which came into existence only after the drug addict was "criminalized."
>
> In recent years the penalties for narcotics crimes have become more and more severe, the theory of the legislation evidently being that the greater the penalty, the greater the deterrence. The result in practice is to glut the penal institutions with small-fry pushers and addicts serving long terms, without any deterrent effect on the racket but with deteriorating effect on the prisoners and the correctional institutions. *We oppose mandatory terms in narcotics cases and the exclusion of narcotics offenders from eligibility for probation or parole.*[1]

In July 1965 the Drug Abuse Control Amendments of 1965 were added to the Federal Food, Drug, and Cosmetic Act, to be effective in February 1966. The new law requires that record keeping be increased in the manufacture and distribution of stimulant and depressant drugs other than narcotics and marijuana, which are covered by the Harrison Act, and gives the Food and Drug Administration investigatory powers somewhat similar to those currently held by the Bureau of Narcotics. Agents are authorized to seize stimulant and depressant drugs being manufactured or distributed illegally and to arrest persons engaged in illegal activities.

Precisely which "dangerous drugs" (barbiturates, amphetamines, tranquilizers) are covered by the new legislation is not specified, such classification having been made the administrative province of the Secretary of Health, Education, and Welfare, who is to act on the advice of a committee of nongovernment experts. Prescriptions for drugs to which the new law becomes applicable will not be valid for more than 6 months, nor may they be filled more than five times without reauthorization from the prescribing physician. Persons over 18 who sell or give these drugs to anyone under 21 are subject to imprisonment for 2 years and a fine of up to $5,000 for a first offense. Imprisonment of up to 6 years and fines of up to $15,000 may be imposed for subsequent violations.

Enforcement provisions are based on stock inventory records and require records on production, shipment, and sales kept by manufacturers, wholesalers, pharmacists, and dispensing physicians. Thus, unlike the Harrison Act as administratively interpreted, this law is not directed at the drug user, even if his drug has been obtained illegally, and possession as such is not punishable. (However, some States—such as New York—penalize possession also.) The House Interstate and Foreign Commerce Committee, which studied the legislation, reported that it was "mindful of the difficulties which this country had in its attempted regulation of alcoholic beverages and therefore has provided for regulation of depressant and stimulant drugs by increased record-keeping and inspection provisions rather than by imposing more rigid controls." [45]

PUBLIC HEALTH SERVICE HOSPITALS

Although most legislative emphasis has been on attempting to regulate drug traffic and on punishing the individuals involved in it, some attention has been given to treating the addict, for it has become clear that "the authority of the drug habit is greater than the authority of the law; and once established, the desire for drugs cannot be eliminated by legislation." [32]

In 1929 Federal legislation authorized establishment of Public Health Service hospitals where narcotic addicts could be treated. Voluntary as well as convicted patients were to be admitted if beds were available. Consequently, in 1935 and 1938 respectively, facilities were opened in Lexington, Ky., and Fort Worth, Tex. Much valuable pharmacological research on the addicting properties of various drugs has been done at these facilities, which together have accommodations for about 1,800 inmates (about half at any one time are involuntary admissions). Individuals admitted to these institutions are detoxified medically, and some attempt is made to rehabilitate them. A recent Public Health Service booklet [40] says of the program at Lexington:

> Fewer than a fourth of the patients get any formal psychotherapy, partly because the staff is too small and partly because many patients resist it or are judged incapable of being benefited by it. However, all activities of the hospital are designed to have therapeutic value for people who, by and large, have never quite grown up, distrust everybody in authority (and virtually everybody else), and have substituted drug-taking for practically everything that occupies other people.
>
> All physically able patients are assigned to jobs. For almost all types of work there is a training program that helps prepare the patient to get and hold a job when he is discharged. The primary purpose of the vocational program, however, is not to get patients on payrolls but to help them establish work habits and learn to work with other people. This means that they have to learn to put some controls on themselves and also to accept authority.

CIVIL COMMITMENT PROGRAMS

State programs incorporating "treatment" aspects have been initiated in California, New York, and some other States. In California, any addicted individual may volunteer for, or be sentenced to treatment in the California Rehabilitation Center. He must stay at least 6 months, possibly as long as 5 years. After release on parole, he must remain drug-free for 3 consecutive years.

Under the 1962 Metcalf-Volker bill in New York State, an arrested addict who was not otherwise ineligible (a high percentage of people were ineligible as a matter of law) could apply for civil commitment in lieu of prosecution. Upon successful graduation from the program and after a lapse of 3 years, the charges would be dropped. If the addict "failed," he would be returned to the court for belated prosecution of the charge. If an eligible addict desired treatment, he had to surrender his right to bail as well as his right to a trial regarding his guilt or innocence. But the vast majority of drug users who were eligible for the program did not even apply for it, apparently preferring the usually shorter prison term to the alternative of undergoing treatment.

Metcalf-Volker was an initial step toward the system of universal compulsory treatment of addicts instituted in 1967 in New York. That the system is popular is obvious—except that no neighborhood seems to want the treatment facilities nearby. But unfortunately, the New York State system continues to be a system to protect the public, rather than a program to rehabilitate narcotics users.

Failure by the States to sponsor rational differentiated treatment programs, based on techniques that have been proven to accomplish desired ends, is understandable. No such large-scale program is available as a model. So New York, for example, intends to accredit many different, and separate, programs. But in first instituting a system of compulsion, rather than making available, supporting, and evaluating a broad spectrum of modalities, New York and California have got themselves a baroque structure without a sensible content. There is no reason whatever to suppose that making unproven treatment arrangements mandatory will in any way benefit the patients.

The civil commitment approach again emphasizes the irony of inconsistent public policy toward the addict as "a criminal who ought to be hospitalized." As Alexander King said of Lexington: "For some unimaginable appeasement of purely verbal protocol, all the prisoners, including the ones who are serving fifteen years, are called patients by the staff." [23] It is entirely possible that if there were no law which served to separate the "criminal" addict from conventional medical practice, it would not be necessary to have other laws which allow the "sick" addict access to institutional treatment.

RESIDENCE FACILITIES

In New York City, convicted male narcotics violators may be paroled to Daytop Lodge, a residence on Staten Island operated by the Division of Parole and largely financed by funds from the National Institute of Mental Health. The facility is administered by ex-addicts, and methods are largely modeled on those developed by the "anticriminal society" of Synanon, the difference being that admission and stay at the privately operated Synanon Foundation residences are voluntary. Recently an adjunct to Daytop Lodge, called Daytop Village, has been established. The Village accepts both men and women and is open to voluntary admissions not referred through the courts. Both Daytop and Synanon feel that addicts can most successfully be treated by ex-addicts, and the staff of both are promoted from within. The facilities emphasize a form of group psychotherapy known as "reality" or "attack" therapy, and are particularly concerned with the development of a responsible sense of self-sufficiency among their members.

HOSPITAL PROGRAMS

Until recently, individuals who desired medical detoxification or withdrawal and could not afford to go to private sanitoriums had only the U.S. Public Health Service hospitals at Lexington and Fort Worth to turn to. Lately an increasing number of State and municipal hospitals have added local hospitalization facilities specifically for addicted persons admitted voluntarily. One such community program is in operation at New York City's Metropolitan Hospital. Individuals are detoxified by the methadone-substitution method over a period of about 2 weeks, spend about the same time in a rehabilitation ward, and are then eligible for medical discharge. However, as with other programs of this type, as well as with the voluntary program at the Public Health Service hospitals, a major portion of those admitted leave before the time recommended by the doctors. The Metropolitan Hospital program places great emphasis on aftercare, including financial, family, and housing services, vocational counseling, legal advice, and recreational activities.

OUTPATIENT TREATMENT

In February 1962, the Medical Society of the County of New York stated its position that "physicians who participate in a properly controlled and supervised clinical research project for addicts on a noninstitutional basis be deemed to be practicing ethical medicine."

This research was to include the prescribing of narcotics. Although no such completely noninstitutional program is yet in existence, several institution-based programs involved with the administration of narcotic drugs to addicted persons are in operation, and in New York State are specifically authorized by a 1965 law. The current most extensive maintenance research program is directed by Drs. Vincent Dole and Marie Nyswander at Manhattan's Bernstein Institute of Beth Israel Medical Center. Noninstitutionalized addicts, whose drug tolerance has been deliberately built up during an initial 6-week hospitalization, are daily given high "blocking" dosages of liquid methadone which eliminate the craving for drugs and block the effects of any opiates if they are taken. The program is still in the experimental stage, and no definitive reports on it have been published. Preliminary evidence,[11] however, seems encouraging in that individuals in the program have been able to establish satisfactory relationships with the community in terms of work, schooling, and other conventional areas, while eliminating the criminal activities previously necessary to obtain drugs.

II. PHYSICAL, PSYCHOLOGICAL, AND SOCIAL ASPECTS OF ADDICTION

Drug addiction was defined by the World Health Organization in 1950 (in 1961 the term was changed to "drug dependence") as the "state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and generally a physical dependence on the effects of the drug; (4) an effect detrimental to the individual and to society." [14] This definition conveys the idea that drug use involves the individual physically and psychologically, and has social ramifications as well.

PHYSICAL ASPECTS OF ADDICTION

The valuable contribution of the opiates to medical practice is due to their analgesic effect in relieving somatic pain. Morphine and the synthetic opiates are widely prescribed by doctors for the effective relief of both chronic and acute physical pain. But the person who becomes an "addict" almost never does so as a result of acquired physical dependence on medically prescribed narcotics, though some chronically ill or aged and terminally ill persons are, of course, physically dependent. As the Public Health Service says:

> Last century the pain that led to addiction was often physical; today it is mainly psychic. Most of today's addicted persons have discovered, in other words, that opiates relieve their anxieties, tensions, feelings of inadequacy, and other emotional conditions they cannot bring themselves to cope with in a normal way.[40]

But no matter what the initial reason for taking narcotics, a predictable physical situation is brought about in the body as dosage is continued. The user whose drug of choice is heroin may experience an extraordinary feeling of well-being or euphoria when the narcotic is taken (this euphoria is a "side effect" to the pain-relieving capability, and has been much reduced in the synthetic opiates). In addition, the depressive actions of narcotics result in muscular relaxation, decreased motor activity, drowsiness, and lethargy. Thus, the user may go "on the nod," a pleasant, unaggressive, dreamy state in which he appears sleepy, his reaction time is slowed, but his mental functioning seems otherwise unimpaired. The state becomes progressively less pronounced after several hours, and the individual returns to a more normal appearance as the effects of the drug wear off.

In the physically dependent individual, this lessening of pleasant sensations is accompanied by the onset of a distressing constellation of effects called the "abstinence syndrome." To avoid great discomfort, another dose must be taken. But as this process extends over time, "tolerance" develops. That is, equivalent dosages produce less effect; in order to obtain an accustomed effect, progressively larger dosages must be taken. The body adapts to the presence of the narcotic in such a way that the addicted person comes eventually to need dosages large enough to make seriously ill or even to kill a person not tolerant.

The mechanism of tolerance is incompletely understood, as are the causes of the withdrawal sickness, but both are thought to be related to the action of forces which keep the body's chemical processes in balance. Perhaps cellular metabolism is in some way altered from narcotic use or perhaps some change occurs in the coating of certain nerve cells; in any case, the body attempts to compensate for the depressant effect of the drug (morphine, for instance, may often slow the activity both of the sexual glands and of the adrenal glands, whose hormones help the body meet stress), and in so doing makes increased dosages necessary to attain that effect.[21,31]

Since the drug-dependent person's body has attained a relative chemical balance with the narcotic present, if it is suddenly withdrawn (not replenished) a state of severe physiological maladjustment occurs. Therefore medically supervised withdrawal or detoxification is accomplished by gradually reducing the intake of the addicting drug. (In the case of heroin the synthetic narcotic methadone is generally used instead, since all the opiates exhibit "cross-tolerance" and may be used interchangeably; methadone has the advantages of being virtually noneuphoric, effective in oral administration, and much longer lasting than heroin.) This gradual reduction of dosage minimizes the discomfort and physiological shock associated with withdrawal.

When a habit is "kicked cold turkey," that is, when regular narcotic intake is halted abruptly, the user suffers from symptoms which reach a peak at about 24 hours and may continue with lessening severity for as long as a week. A vivid medical account of acute withdrawal sickness follows:

> As the time approaches for what would have been the addict's next administration of the drug, one notices that he glances frequently in the direction of the clock and manifests a certain degree of restlessness. If the administration is omitted, he begins to move about in a rather aimless way, failing to remain in one position long. He is either in bed, sitting on a chair, standing up, or walking about, constantly changing from one to another. With this restlessness, yawning soon appears, which becomes more and more violent. At the end of a period of about 8 hours, restlessness becomes marked. He will throw himself onto a bed, curl up and wrap the blankets tightly around his shoulders, sometimes burying his head in the pillows. For a few minutes he will toss from side to side, and then suddenly jump out of the bed and start to walk back and forth, head bowed, shoulders stooping. This lasts only a few minutes. He may then lie on the floor close to the radiator, trying to keep warm. Even here he is not contented, and he either resumes his pacing about, or again throws himself onto the bed, wrapping himself under heavy blankets. At the same time he complains bitterly of suffering with cold and then hot flashes, but mostly chills. He breathes like a person who is cold, in short jerky powerful respirations. His skin shows the characteristic pilimotor activity well known to those persons as "cold turkey." The similarity of the skin at this stage to that of a plucked turkey is striking. Coincident with this feeling of chilliness, he complains of being unable to breathe through his nose. Nasal secretion is excessive. He has a most abject appearance, but is fairly docile in his behavior. This is a picture of his appearance during the first 8 hours.
>
> (Subsequently) lacrimation, yawning, sneezing, and chilliness are extreme. A feeling of suffocation at the back of the throat is frequently mentioned. Usually at this stage, the addict complains of cramps, locating them most frequently in the abdomen, but often in the back and lower extremities. A right rectus rigidity with pain localized over the appendix region is not uncommon; one can easily be misled in the diagnosis, since at this stage a leucocytosis is frequently present. Vomiting and diarrhea appear. He may vomit large quantities of bile-stained fluid. Perspiration is excessive. Muscular twitchings are commonly present; they may occur anywhere, but are most violent in the lower extremities.[28]

There is no question that some physical discomfort attends withdrawal. Just how severe that discomfort is depends on the amount of narcotics the individual has become dependent upon. In addition, an important factor seems to be the circumstances and environment in which withdrawal occurs.

Individuals who "kick cold turkey" in a jail or hospital often exhibit symptoms fully as dramatic and alarming as those described above. But the Synanon residences report [24] that withdrawal without any kind of medication is accomplished with considerably less apparent discomfort and histrionics by new inmates under the rather casual observation of resident ex-addicts, who are perhaps less likely to be moved than are medical personnel. At any rate, the way individual reactions to the withdrawal sickness vary suggests that in addition to purely physical components, addiction has psychological and environmental aspects as well, and is a function of both personality and social situation.

PSYCHOLOGICAL AND SOCIAL ASPECTS OF ADDICTION

An examination of the psychological and social aspects of drug use in the U.S. faces three immediate difficulties: (1) historical data is almost entirely lacking, and that which does exist is of limited value; (2) because the use of heroin is illegal and extremely unlikely to be advertised by the user, studies are done only of those individuals either in jails or hospitals, while those who do not come into contact with such institutions largely go unstudied; and (3) the emerging problem of the abuse of dangerous drugs other than opiates seems to have even greater proportions than that of heroin addiction, but this development is of such recent origin that very limited research data exist on the reason for it, the individuals affected, or the consequences for the community.

DEMOGRAPHIC DATA

Bearing these disclaimers in mind, it nevertheless seems possible to enumerate some differences between groups of narcotics users today and those in the past. Lindesmith and Gagnon, in *Anomie and Drug Addiction,* note that during the 19th century,

> approximately two-thirds of the users were women. Most nineteenth century observers had the impression that addiction was less prevalent among Negroes than among whites, and slightly less prevalent in the lower than in the upper middle classes. The usual concentration in the medical profession was noted. The average age of addicts was found to be from about 40 to as high as 50 years, and some investigators observed that addiction was a vice of middle age usually taken up after the age of 30.[8]

In the 20th century, and particularly in the last two decades, a number of changes in the pattern of drug use have occurred in America. These include: an increase in involvement with addicting drugs by young persons, as indicated by the steady increase of individuals under 18 arrested on narcotics charges, in combination with a decrease in those over 40 arrested; an increase in drug use in the lower socioeconomic classes; an apparent concentration of narcotics use in minority racial and nationality groups; a concentration of use in large urban centers; and an increasing tendency to multiple substance use, including the abuse of a great variety of barbiturates, amphetamines, tranquilizers, hallucinogenic drugs, and such etherials as glue and gasoline.[34]

Recent (1961) demographic data[40] on individuals admitted to the Public Health Service Hospital at Lexington indicates that about three-fourths of the patients were men, and three-fifths were white (including Puerto Ricans, who made up about a tenth of the total admissions). Seventy-four percent were between 20 and 39 years old. About a third were married. Fifty-three percent claimed to be unemployed. Sixty-eight percent had not finished high school. Eighty-five percent were from the lowest of five socioeconomic levels.

In New York City, the 1962–63 census[33] of admissions to the narcotics wards of Metropolitan Hospital indicated that of the admitted patients, all male, 39 percent were Puerto Rican, 35 percent Negro, and 24 percent white. Median age was 25 years; 56 percent were between 21 and 30. Thirty percent were married at time of admission; 46 percent had at some time been married. Fifty-eight percent were Catholic, 35 percent Protestant, and 4 percent Jewish. Median school grade completed was ninth grade; 82 percent had not finished high school, though 4 percent had some college. Seventy percent said their father was a blue collar worker.

PSYCHIATRIC CLASSIFICATION

About 90 percent of their patients were classified by the Lexington doctors as "easily frustrated, impulsive, unstable, and unable to plan ahead; in the hospital they were often childishly demanding and stubborn." This kind of description of the drug user is often given by treatment personnel. A major contributing factor may be the disparity between what the individual really wants and what treatment personnel feel he ought to want, a situation which is considered in some detail in appendix D. The American Medical Association, for instance, states in *Narcotics and Medical Practice*:

> Disturbances of personality are usually easy to discover in persons who have become addicted and these disturbances are thought to precede and predispose to the occurrence of the disorder rather than being caused by the

> addiction. Expression of the personality disorder is aggravated by the use of drugs, but full-blown psychoses are rarely associated with the opiates except for toxic psychoses caused by intoxication with or withdrawal from non-opiate drugs.
>
> Addicts as a group are lacking in frustration tolerance, are dependent and adept at manipulating those about them in relation to their addiction. They are very often amoral, hedonistic, unreliable, and difficult as patients, yet it is wrong to generalize too freely since much depends on the structure of individual psychopathology, the social and cultural background, and the patient's total physiological and psychological resources.[10]

Dominant psychiatric diagnoses of the 1962–63 narcotic ward admissions to Metropolitan Hospital were: personality disorders, 87 percent; schizophrenic reactions, 13 percent. Twenty-two percent of the total were given no other diagnosis than "drug addiction" which is listed in the American Psychiatric Association's *Diagnostic and Statistical Manual* as a specific type of sociopathic personality disturbance. Many of the patients were diagnosed by different therapists, and different diagnoses often resulted, partly due to the use of "drug addiction" as a diagnosis by some examiners.

Psychological factors predisposing the individual to drug use have been the subject of much speculation, but as yet no single theoretical formulation to explain psychiatric factors in the etiology of addiction has been found to be entirely satisfactory.

The psychoanalytic formulation emphasizes the narcissistic, passive-dependent, orally fixated qualities among drug dependent persons.[16] In a recent book,[25] Drs. Yves Kron and Edward Brown make the following statement:

> Three major trends characterize the male urban addict in the United States. Each of the three is always present, and the addict personality varies according to which trend is dominant:
>
> (1) Psychopathic acting-out, with exaggeration of the need to steal and to hurt others;
>
> (2) Passive dependency (these addicts are marked as ideal tools for pushers, ringleaders, and authorities of any kind; most police informers are recruited from among them);
>
> (3) A schizoid distortion of reality which can reach the psychotic level with delusions and even hallucinations.

A 1951 Bellevue study[49] described adolescent users as characteristically non-aggressive, soft-spoken, verbally adept, pleasant, likeable, and sociable. They showed a close empathic relationship with the mother, weak object relationship with others, omnipotent strivings, and a tendency to regression with a readiness to assume a more immature and less socially organized form of adaptation. A Lexington report[15] at the same time described a widespread and appreciable interest in the arts among the individuals studied.

Again in 1951, in a U.S. Public Health Service pamphlet, Dr. Harris Isbell stated:

> The cause of addiction is not drugs but human weakness. Addiction usually is a symptom of a personality maladjustment rather than a disease in its own right. The psychiatric conditions which underlie drug addiction are chiefly the neuroses and the character disorders . . . The majority of addicts do not fall clearly into either the neurotic or character disorder groups but have characteristics of both classes.[20]

A somewhat broader view was stated by Dr. Charles Winick in 1957:

> There appears to be no one kind of psychiatric diagnosis which is common to drug addicts. All kinds of people can and do become drug addicts. The psychiatric classification of the addict does not determine the progress of his addiction. A patient with a severe character disorder may recover from an addiction in a short time, while a patient with a mild neurosis may be unable to stop taking drugs. In each case, the drug fulfills a specific function in the personality economy of the individual, and it is this function which determines how difficult it will be for the addict to shed his drug. There have been a good many psychiatric classifications of types of addicts, but these classifications often place the majority of addicts in a catchall category, like "psychopathic."[48]

In an address delivered in September 1965, Dr. Dale Cameron reflected an increasing realization that the emphasis on restrictive psychiatric classification fails to take into account other vital factors in addictive behavior:

> We all recognize that drug dependence, whether to alcohol, sedatives, stimulants, or opiates, is almost always a reflection of some underlying mental and/or social disorder or pressure. The underlying mental disorders cover the entire range of psychiatric nosology. And the particular drug of abuse superimposes its own special physical, physiological, pharmacologic, psychological, and social complications and consequences. Ordinarily, drugs are abused in an effort to obtain "relief" from some "intolerable" psychological, social, or physical situation.[5]

However often drug users may show personality deviations, addiction cannot be said necessarily to be caused by these abnormalities. In the first place, all persons with similar traits do *not* become addicts; in the second place, it seems reasonable to assume that some disturbance of personality may arise from the situational factors concomitant to addiction itself. The personality of the addict before addiction is unknown. Thus it is entire possible that the pressures of constant illegal activity, the incessant drive to obtain heroin, and progressive alienation from conventional society may lead to individual psychopathology.[17] As yet no studies have separated the contribution of the personality before addiction from the effects accruing from the social position most users must assume in acquiring illegal drugs.

In his introduction to *The Addict in the Street,*[26] a compilation of tape recorded interviews with Lower East Side New York addicts, Jeremy Larner attempts to describe the problems and attitudes these particular addicts seem to have in common:

> To begin with, these addicts—like most addicts who are not doctors, nurses or druggists—grew up in a crowded, lower-class neighborhood where they were introduced to heroin as teenagers. Bored and delinquent at school, they couldn't face the prospect of starting at the bottom of the social ladder. College was unthinkable, and once school was left behind, there was little to do but hang around the neighborhood, and no group with which to identify but one's comrades on the corner; in brief, no place to aspire to. Small wonder that, when asked why they started on heroin, almost every one of them included in his answer the phrase, "to kill time."
>
> To be sure, they could have gotten jobs (all of them did at one time or another) and worked and saved and become respectable middle-class householders with families of their own. But frequently the model for such industry was missing; in almost every case, the subject reported no relationship or a negative relationship with his father. In lacking a father-figure the addict misses a model of successful relations with the opposite sex as well as a model breadwinner. It seems hardly a coincidence that heroin robs the user of sexual desire; perhaps the tension of such a possibility is simply too much to be endured. As it happens addicts find their friends almost entirely within a male peer group of users, and the injection itself is usually performed in company and with an elaborate fixed ritual. Contempt for women is a constant theme, typically expressed by the remark that women addicts have it easy because they can raise money by hustling.
>
> A vast chasm gapes between (the addict's) self-portrait and his actual needs and desires as expressed through the life he leads. Almost always his urgent flow of words enforces an utter separation between thought and actuality. The compulsive retelling of his story leads not to self-understanding but to rigid isolation.
>
> It is as though the addict is formed from the individual who doesn't dare to be self-consciously angry or frustrated. The addict is he who under pressure simply splits down the middle: he combines the most conventional morals and aspirations with the most completely antisocial behavior. Almost literally, his left hand knows not what his right hand is doing. He lives in the most advanced stage of alienation—alienated even from himself.
>
> No group of people could embrace the middle-class American ideology more fervently than do the drug addicts represented in this volume. But at the same time, no group could engage in activities which by their nature more utterly repudiate and subvert that ideology. Addict after addict swears that all he wants from life is a wife and children, a steady job, a chance to provide his family with the good things of life. Marriage is sacred to him; family is sacred to him; likewise God, church, and country. I'm basically a decent person, the addict insists, though the interviewer is not doubting him. This is the way I would lead

my life . . . if on weren't a drug addict. That's why I got t ck. And he means it.

It doesn't occur him that through his addiction, he fulfil wish to live by a completely different st and value. Despite his protests, he cannot ide living in a family—his own family situation repelled him. He lives instead with other men, as a rule, working in ever-shifting groups, partnerships, and alliances. Drug addicts cannot trust one another, but they are loyal to each other's company. And not, as they maintain, simply because they are ostracized from other's company. They stick together because they need each other to recreate the games of hide-and-seek, cops-and-robbers they enjoyed as children, when they first learned to act in groups of male cohorts. Addicts search for money together, wait for the pusher together, take off together, go to jail together, and—like other playmates—spend endless hours talking together about their adventures.

But the addict can't help knowing that his way is not the way happiness is supposed to be sought. The rest of us may build up and discharge, to be sure, but we are able somehow to do other things as well, to breathe easy for a space between crises and to get outside the pure needs of our cells. To go beyond our need, rather than escape into it. To sublimate, as Freud would have it; to work and love. For this the addict genuinely envies us. Work and love are what he wants, too. Only of course, he is a drug addict. And drug addiction, he repeatedly insists, was thrust on him from the outside. He did not invent it, it was brought to him by profiteers, and he is kept from defeating it by self-righteous Puritans. Yes, he knows he is weak-willed (though next time his will is going to triumph!), but still he cannot forgive the rest of us.

PSYCHOSOCIAL FACTORS

Without resorting to psychiatric diagnosis, Zinberg and Lewis[50] have attempted to distinguish among five operational categories of "addicted" individuals. The first category consists of the type of person who likes to say that he is an addict but who in fact is committed only to the principle of addiction. Typically, he does not use any narcotic at all. Usually he belongs to a social group that admires addiction, or his feigned addiction enables him to feel in control of his particular life situation.

The next type consists of people who do use narcotics but in whom the effect of a drug seems secondary to their emotional involvement with the way in which the drug is taken or with the person who administers the drug to them. The third category includes people who use narcotics regularly but who develop little or no tolerance for them and who do not suffer withdrawal symptoms. Such people are usually able to work regularly and productively. They value the relaxation and the kick obtained from the drug, but their fear of needing more and more of the drug causes them to impose rigorous control on themselves.

The fourth type includes individuals who have overt physical symptoms dominated by severe pain, which may be physiologic or functional. These persons suffer overtly and openly demand narcotics, not because they want them, but because they think they need them. The fifth category consists of the "true" and most commonly studied narcotic addict; these are the individuals who most often exhibit the characteristics previously enumerated, usually prefer heroin if they can get it, and develop true withdrawal symptoms if their drug supply is cut off.

In this classification scheme, particularly in the first two categories, consideration is given to the importance of environmental factors outside the individual. Weight is also given to sociocultural determinants (although the classification is announced as one of predisposing personality factors) in Ausubel's[2] threefold classification of *primary* addiction, in which drugs have a specific adjustive value for particular personality defects, *symptomatic* addiction, in which the drug use is only an incidental symptom of disorder, and *reactive* addiction, in which drug use is a transitory developmental phenomenon influenced by peer group norms. According to Ausubel:

> *Primary* drug addiction includes all addicts with personality trends for which addiction to drugs has specific adjustive value. Two subgroups may be delineated: (a) the inadequate personality, and (b) anxiety and reactive depression states. Of these two subgroups, the inadequate personality constitutes the numerically more important and the prognostically less hopeful variety. Since drug addiction is an almost tailormade adjustive mechanism for this psychological disorder, it may be regarded

as the characteristic personality makeup predisposing individuals to opiate addiction. For the other personality trends, the adjustive value of addiction is less specific and less efficient; hence incidence is lower, prognosis better, and the consequences to both society and the individual less disastrous.

Symptomatic drug addiction occurs primarily as a nonspecific symptom in aggressive antisocial psychopaths. The main disorder itself is a form of gross moral agenesis in which the individual fails to internalize any obligations whatsoever to conform to the ethical standards of society. Drug addiction has no particular adjustive value for this type of person. It is only one minor symptomatic outlet for the expression of his antisocial and aggressive trends. The crimes they commit are not precipitated by the drugs they take. Unfortunately, however, these atypical addicts, who constitute only a very small minority of the total addict population, lend credence to the popular misconception that addiction leads to violent crime and that drug addicts are fiendish, cold-blooded criminals.

Reactive drug addiction is essentially an adolescent phenomenon. It has no adjustive value for any basic personality defect. It is a response to transitory developmental pressures, a vehicle for the expression of aggressive antiadult sentiments, and a means of obtaining acceptance in certain slum-urban peer groups. Reactive addiction is largely a nonspecific aggressive response to the prolonged status deprivation to which adolescents are subjected in our society. It is expressive of a general antiadult orientation characterized by defiance of traditional norms and conventions and flouting of adult-imposed taboos and authority. These motives are especially characteristic of adolescents who are overactive, impulsive, and headstrong, but not necessarily psychopathic in their moral outlook. Under other circumstances similar traits are associated with transitory delinquency.

Indicative of the trend toward consideration of social factors in addiction are these two statements, the first made in 1959 by Kenneth Chapman, and the second in 1962 by William Butler Eldridge:

> Certain social factors appear influential in determining addiction. The addict with a dependent personality structure may come from a social group in which addiction is acceptable and differs only in terms of his use of narcotics from the dependent personality who comes from a cultural subgroup in which addiction is taboo but "neurotic" complaints in one guise or another are commonplace and allowed.[6]
>
> Drug use simply represents the attempt of certain persons to deal with the problems confronting them because of their individual personality structure or the social structure of their communities. It may well be that drugs are a socially undesirable solution to the individual's problems, but, if so, our effort should be directed toward finding a solution that is acceptable.[12]

Clearly, most traditional formulations share two characteristics: they are tentative, and they give little indication of what might be done to alleviate the problems caused by addiction. If we accept as given some chemical activity of the addicting substance itself (the physical aspect of addiction), and those predisposing psychiatric characteristics the individual possesses, which allow addiction without necessarily causing it (the psychological aspect of addiction), it is still necessary to consider, in epidemiological terms, the environment in which the pathogenic agent and the host are brought together. It may thus become possible to appreciate more fully the *process* of drug use and to devise methods of intervening in this process to the benefit of the addicted individual and his community. The next chapter will, therefore, be concerned with some ways of describing and measuring an individual's interaction with and adaptation to his environment.

III. THE COMMUNITY MENTAL HEALTH APPROACH TO DIAGNOSIS

INDIVIDUAL ADDICTION AND SOCIAL DISORDER

Webster's *New World Dictionary* defines disease as "a particular destructive process in an organism." Traditional emphasis on the drug user as the cause and/or the victim of the addiction problem has led naturally to a concentration of treatment efforts—whether legal or medical—on the individual. A more fruitful approach would seem to be to consider the "destructive process" as a dysfunctional characteristic of the sociocultural organism as well as of the individual who exhibits the alarming symptoms, for he himself may *be* a symptom.

Of addictive behavior as a disease of the individual, it has been said:

> Describing addiction as a disease is obviously not accurate in the scientific sense, but it does serve a polemical purpose. "Withdrawal" distress might perhaps be termed a disease or disorder, but addiction encompasses much more. It is, in reality, a complex, poorly understood type of behavior, involving phenomena on the biological, psychological, and social levels. It is called a disease and declared to be a medical problem primarily to emphasize that force ought to be used with respect to it as a last resort.[31]

One advantage of bringing medical practice to bear on addiction is, of course, that there has been considerable public health experience in dealing with problems involving similar combinations of individual and social factors. Law enforcement officers often speak of the drug user as a "Typhoid Mary" who spreads the contagion of addiction. But it must be remembered that such an individual might be just one "indicator" in an epidemic, the control of which involves attention to such extra-individual factors as food and water supply. Similarly with venereal disease. The individual affected may well have engaged in some unacceptable activity in order to contract the disease and thus become a visible indicator of its existence in the society, but he is neither jailed nor otherwise punished on the basis of individual infirmity. In this case, individual medical attention brings about remission of individual symptoms, but, as a public health problem, treatment must extend beyond the individual to the field from which the problem emerges.

Traditional—and misplaced—emphasis on the individual as the problem has unfortunate effects which are widely apparent in many contemporary areas other than addiction. Recent programs to help the poor by redefining them as the "underprivileged" (or "undertrained"), while giving some recognition to the fact that the sociocultural environment may be responsible for the existence of these difficult people, nevertheless generally try to alleviate the problem by changing the people. As a national news magazine put it, "The U.S. hopes not merely to balm the distress of the poor but to reshape their skills, attitudes and even their personalities."

It is tacitly assumed that if the individual is sufficiently trained and motivated, he can somehow "re-enter the mainstream"—though he may never have been in it to begin with. Therefore attempts are made to change individuals rather than systems, which are instead "improved." The result is that many of those who are unhappy and troublesome remain unprotected and unrewarded, and just as troublesome.

Yet there is available in public health medicine a model which points the way for dealing with that kind of problem which is at once indicative of both social and individual disorder. The model is not strictly a medical one, for when the individual is seen simply as "chronically ill" he is just going to end up with the kind of processing which attempts to cure one who is sick. Certainly individuals must be cared for personally. But they should also be used as indicators and measures of the type and extent of a community problem, and the major arena for confrontation of that problem should be the *environment* in which it arises.

THE OBJECT OF DIAGNOSIS

The way a problem is diagnosed affects the way it is treated. The community mental health approach to diagnosis of problems such as narcotic addiction places emphasis on factors concerned with the way individuals interact with, adapt to, and are affected by the community.

The undesirable social behavior of drug users has in the past been studied primarily by law enforcement agencies. It is the purpose of the community mental health approach to look carefully at the same kind of data these agencies do, to go further and relate the deviant dimension of behavior to a whole range of conventional behavior, and then to relate the whole spectrum of individual behavior to public policies and environmental pressures. As a result, it will be seen that possibilities for intervention lie both within the individual and in the community. Suggested methods for effecting desired change in these targets is the subject of chapter IV: first it is necessary to pinpoint areas where intervention is likely to be useful.

Community mental health diagnosis, like other types of diagnoses, is based on examination of an object thought to be in need of it. In the case of narcotic addiction, a clear appreciation of just what ought to be the subject of examination is made difficult by admitted gaps in biochemical knowledge, detrimental legal policies, broad public misunderstanding, and a still limited sociological research armamentarium which can be brought to bear on this kind of problem. Placing the addicted individual in prison is an appallingly gross technique for dealing with a complex situation. Obviously all the relevant factors are not embodied in the addicted individual; the jails fill and society *continues* to experience drug dependence.

Somewhat more subtle methods of adjustment and repair in specified areas can and do lead to more favorable results. The question arises, "How are the areas to be specified?" It is possible to measure and evaluate an individual's physical and mental functioning. It is also possible to measure and describe his social functioning. But it is exceedingly difficult, if indeed it is possible at all, directly to test, measure, describe, or evaluate the functioning of a system called *the community*. Even to determine on a subjective basis the quality of interaction of half a dozen social agencies is difficult. But when one tries to objectively research the interconnected effects of these agencies, administrative procedures of numerous others, official public policy in many related areas, law enforcement methods, the influence of the popular press, the quality of urban family life and available housing, the opportunities for satisfying work and recreation, and the attitudes of professional "helping" personnel—to name but a few relevant considerations—the result is a virtually unmanageable tangle of interacting variables.

But a useful vantage point is available from which to study this community system. It is, of course, the drug user himself who stands out, either because he calls attention to himself and his particular problem, or because the community has made him visible by giving him attention of some kind.

This individual may initially be diagnosed as being in need of individual care—for instance, there may be immediate health needs to be met—but consideration of these individual needs leads to consideration of pertinent community resources, policies, and attitudes. Drug users may be ostracized from decent hospital care; they (and their families) may be subjected to harshly discriminatory public assistance policies; they may be generally rejected as immoral.

To ask "What is the issue here?" when confronted with such an individual who represents a social problem, as the drug user does, produces case after case in which much more than the individual has to be dealt with. Thus the individual who is studied directly serves as one device through which dysfunctional aspects of the community system may be studied indirectly.

AREAS FOR EXPLORATION

The community mental health diagnosis of dysfunctional behavior includes areas traditionally encompassed by both medicine and sociology. Since the object for investigation is the-individual-in-relation-to-the-community, primary importance must be attached to immediate analysis of the following content areas: presenting problems, health, substance use, residences, family, friends, organizations, education and occupations, recreation and leisure, and criminal activities. Some specific considerations in each of these areas follow.

Presenting problem: source and route of referral and factors precipitating referral as perceived by the referring agent (whether personal or institutional), indicating present or possible relation of referred individual to the community system; interpretation of the problem from the afflicted individual's viewpoint and his perception of his relation to and aspirations regarding sources of help.

Health: subjective and objective measures of individual continuum of physical and mental health and/or illness; presenting symptoms; history of medical care; present health needs and resources.

Substance use and history: type, frequency, and amount of past and present (simultaneous and sequential) substance use; drug influences (and correlated community influences) on conventional activities and social relations; history of institutionalizations and other dysfunctions related to narcotics use; attitudes regarding drug use and the addict culture.

Residences: history of individual geographical movements; type of housing and surrounding neighborhoods; present physical household (living conditions): location, rent, size, relation to individual needs.

Family: composition and description of families of origin and procreation; past and present relationship of individual to these families: scope, degree, and nature of contact.

Friends: style of informal associations; patterns of friendship; basis of relationships; extent of conventional and/or criminal associations; present identification with informal reference groups; association with peer groups prior to and during drug use history.

Organizations: past and present membership in and relation to formal associations (social, political, religious, etc.); history of contact with and use of public and voluntary community "helping" agencies.

Education and occupations (socioeconomic status): educational history and aspirations; job history: types of work, duration, income, satisfactions; present and planned employment situation.

Leisure and recreation: use of time; types of activities and place of occurrence; individual perception of time use; extent of structured purposeful activity; extent and degree of recreative interaction with others.

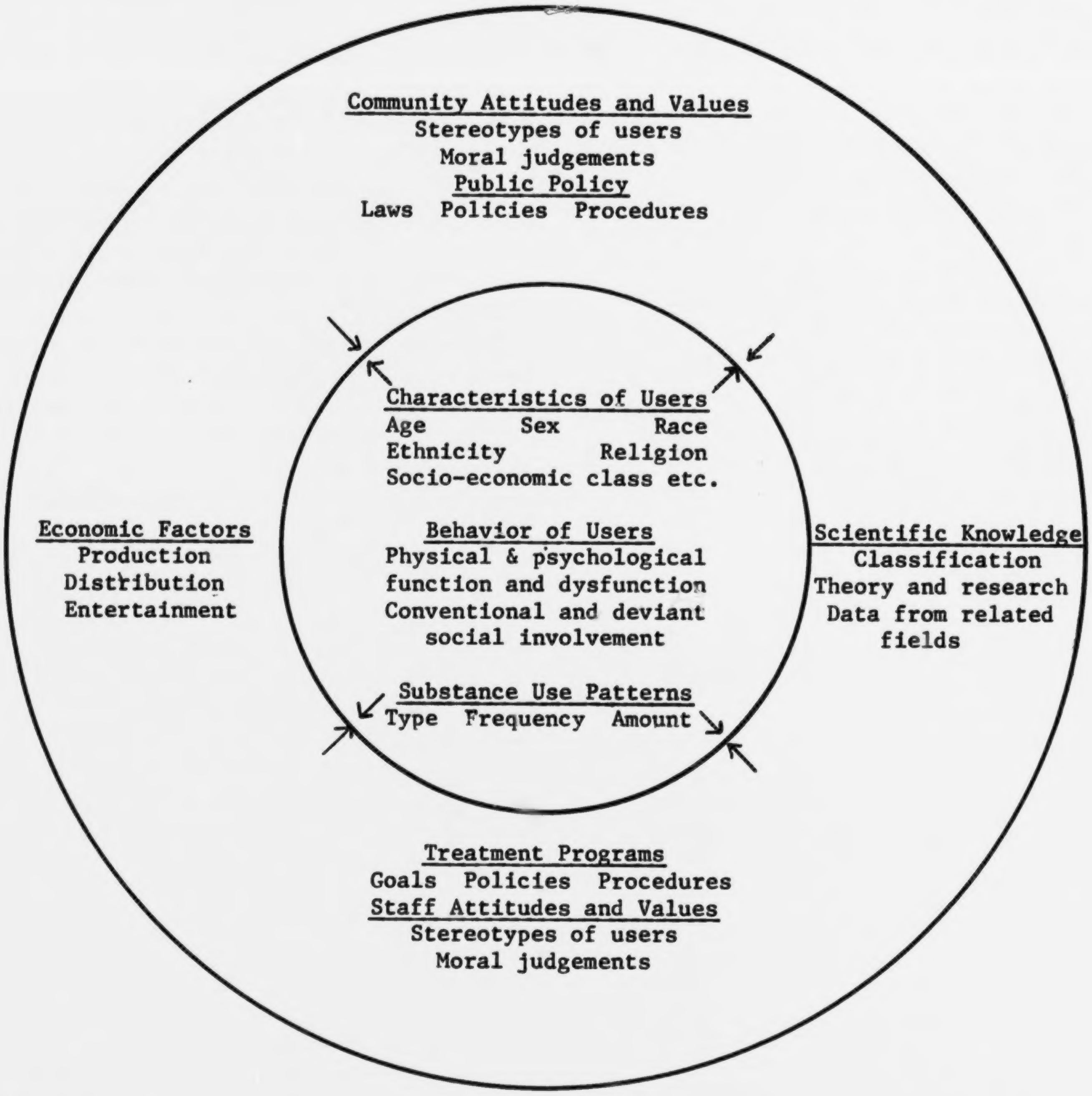
Criminality: type and frequency of marginal activities; involvement with criminal subculture; relation of criminality and drug use; associated institutionalizations and other clashes with conventional structures.

The specification of these areas devolves from the choice of the individual as the vantage point for examination of a system of community interaction. These areas can first be studied through direct work with the individual; that work conveniently takes the form first of a structured, evaluable interview, as discussed in the next section. Since, in our view, the "case" inevitably includes more factors than the single individual showing dysfunctional behavior, additional vantage points and sources of information are subsequently brought into play. The individual, however, is used as the *point of entry* into the social problem.

Chart I is a graphic presentation of the overall social-problem field of narcotic addiction, the dimensions of which become apparent when the individual areas outlined above are considered as indicators of function and dysfunction. It is clearly necessary to distinguish between certain necessary sequelae of abuse of a substance itself—such as liver damage, respiratory failure, or toxic psychosis—to distinguish between these individual effects and the interactional difficulties which devolve in large measure from the way in which the phenomenon is approached by others. That is, although the type, frequency, and amount of the particular substance used play a considerable role in shaping "the problem," there are many other factors which have to be considered, too.

The chart is meant to provide a more comprehensive view of the communitywide problem of drug addiction, a view which can lead to logical and rational planning of community efforts aimed

CHART I


Community Attitudes and Values
Stereotypes of users
Moral judgements
Public Policy
Laws Policies Procedures
Characteristics of Users
Age Sex Race
Ethnicity Religion
Socio-economic class etc.
Behavior of Users
Physical & psychological
function and dysfunction
Conventional and deviant
social involvement
Substance Use Patterns
Type Frequency Amount
Economic Factors
Production
Distribution
Entertainment
Scientific Knowledge
Classification
Theory and research
Data from related
fields
Treatment Programs
Goals Policies Procedures
Staff Attitudes and Values
Stereotypes of users
Moral judgements

at the prevention of this social health problem. Prevention is interpreted in the broad sense of the public health model: primary, secondary, and tertiary prevention involving early detection and education, treatment and rehabilitation, and chronic care.

The primary question in planning is, "What is the nature of the problem of dependence?" The etiology of addiction may well be considered the problem; that is, what are the physical, psychological, social, and cultural factors which relate to drug use? For the most part, past efforts have been aimed at the segments of the etiological model rather than at the whole. That is, some individual efforts are aimed at the physical aspects, others at the psychological aspects, and still others at the social aspects of the problem. It might therefore be suggested that the lack of an overall etiological model of addiction represents "the problem." The chart attempts to relate the many relevant etiological variables, and each area is discussed below.

Drug addiction does involve the use of specific substances, and most early efforts in the field focussed on the *substance use patterns of drug users*—the type, frequency, and amounts of consumption of the drug of choice. The fact that the individual uses four bags of heroin five times a day, perhaps in combination with other substances, is a significant part of the problem. However, to focus on this single aspect is generally recognized as limiting and inadequate in viewing the problem. Because of the changing patterns in drug traffic and the lack of knowledge about the actual constituents of illicit drugs, one cannot usually establish what amount and frequency really mean.

The *characteristics of drug users* have come naturally to the fore as another area of concern. It has been variously stated that the problem of drug addiction is related to the fact that users are in a particular age group, generally of minority group background, in a low socioeconomic bracket, generally single, with poor education (mostly dropouts), and little—if any—vocational skills. These characteristics of some of the addicted population are certainly important to the consideration of the problem as a whole, but they are not characteristics of the whole population, and the relationship between personal characteristics and drug use does not seem to be one of cause and effect.

The most obvious factor in the problem of addiction is the *behavior patterns of drug users*, particularly in relation to their criminal activity. For the most part, this criminal activity is viewed as including not only those criminal acts required to obtain money for drugs and sustenance, but the actual possession and use of the drugs themselves. This focus of interest leads one into an overriding concern with abstinence and an immediate concentration on making the drug user give up his drug, his criminal activity, and his generally unacceptable social behavior. This view takes into consideration the user's social patterns of behavior. Another view focuses on the drug user's psychiatric pathology; often all drug users are considered as psychiatric cases, in that the use of the drug itself is considered to be pathological. In still another instance, the focus is on the physical effects of the drug on the user and the relationship of drug use to the total physical well-being of the individual.

At this point it is evident that the major efforts in drug addiction have been aimed at the individual aspects of the problem (those within the inner circle on the chart). Now let us consider some of the less obvious factors which relate to the problem, factors which might generally be termed the *community* aspects, and which are also shown on the chart.

The very *attitude* which focuses upon the users as "the problem" and characterizes them as pariahs and evildoers is an important factor. The stereotyped images of users as fiends, thieves, and killers which result from such attitudes may seriously affect progress toward understanding. This attitude has recently been adjusted somewhat to view the user as a "sick" person—sick being interpreted as meaning psychiatrically ill. This results in another stereotyped image. Whatever the image, thus far society has succeeded in placing the unwanted addict in an isolated position, much as has been done with the mentally ill or other persons who represent problems with which society is not yet able to cope. The *values of society* therefore play their part in the problem of addiction.

Based upon these attitudes and values, *public policies* are developed which reflect the basic attitudes and values. The Harrison Act and its amendments, the Federal dangerous drugs legislation, state narcotic laws, and public and private agency policy have all contributed to the further isolation of the addicted person and the perpetuation of stereotypes and myths about the problem of drug use.

A great deal of money changes hands as a result of the existence of the addiction problem; thus *economic factors* figure prominently in the total situation. Certain elements in society profit directly from the distribution and sale of illicit drugs. (In the case of other dependence-producing substances, such as alcohol, the profit motive is even more far-reaching, encompassing among others the agricultural, manufacturing, and entertainment industries.) Personnel of many different research, care, and control organizations are paid to deal with the existing situation. Meanwhile, in some communities it has been found that the addict represents a useful source of goods, and extensive advantage is taken of the fact that an order for groceries or a television set can be placed in the morning for delivery at wholesale prices in the afternoon.

Treatment programs and treatment staff concerned with the population of addicted persons tend to reflect attitudes and values similar to those held by the community as a whole. Working with substance-dependent persons is notoriously exasperating (primarily because we keep trying to "cure" the wrong thing), and eventually we conclude that recalcitrant cases are poorly motivated or simply uncooperative. Then too, social workers find that hospital personnel are singularly resistant to caring for the drug users who are obviously in need of medical attention, while medical personnel wonder why rehabilitation agents can't seem to take whatever action is necessary to keep addicts from coming back for detoxification time and time again. Abstinence has long been viewed as the goal of treatment. Little emphasis has been placed upon social rehabilitation as the primary goal, and where rehabilitation is viewed as a goal, individual phased plans have been difficult to specify and carry out. Practically nothing has been done in relation to early detection, case finding and primary prevention, or community education.

At the base of the confusion and ambivalence of the general and professional society in relation to drug use is the lack of scientific knowledge about addiction. This basic and major weakness is reflected throughout the system. It is apparent that one factor is the as yet inadequate application of social science skills and knowledge to this situation in order to present logical, rational, and reliable data upon which further understanding might be based. Little time and effort have been devoted to the formulation of adequate theoretical frameworks within which scientific inquiry might take place.

In summarizing the community aspects of the problem, one could point to societal attitudes and values, public policy, treatment programs and staff, and the lack of a body of scientific knowledge about the addictions as major contributing factors.

A comprehensive view of the problem requires that both the individual and community aspects of drug use be taken into account, for it is the quality of interaction of these individual and community elements which determines the seriousness of the problem. In other words, taking a deviation-amplifying system as a model, the greater the furor raised by public officials, treatment agents, and the community in general, the greater will be the problem of narcotic addiction in the U.S. The more deeply ingrown the attitudes and values which label the drug user as criminal, as outcast, the more serious the problem. On the other hand, the greater the degree to which the individual is viewed as a source of knowledge and inquiry, as a source of understanding and scientific data, the greater will be the opportunity for alleviating this situation.

Although the initial object of examination is an individual, the eventual subject of examination is the total situation in which that individual finds himself. Therefore, we will consider a specific method of gathering relevant information for immediate work with the individual and, in later sections, for critical analysis of a system or process through operations research, that is, analysis based on initially disconnected data obtained from the individual units of observation.

THE STRUCTURED INTERVIEW

A screening instrument for gathering the kinds of data just described is reproduced in appendix B. It was specifically constructed for a demonstration project in substance abuse, combining goals of action (treatment and rehabilitation) and training, as well as research. Therefore, the instrument serves other purposes in addition to research—classification preliminary to diagnosis, the preliminary planning of goals and methods of intervention, and the documentation of case-study materials.

The screening interview schedule is designed in large part to implement a survey design in the study of any disorder for which a concept of "life style adaptation" may be relevant; a specific section of the instrument concentrates on the particular disorder under consideration.

Life style adaptation refers to characteristics of an individual indicating his relations to sociocultural institutions. More specifically, life style adaptation focuses on spheres such as work, family, and friendship, and also on contacts with agencies of care and control. The main interest is in the positions, associations, attitudes, practices, and episodes which have been descriptive of the individual in the various areas of his life space.

Logically, the life style adaptation concept involves a level of abstraction different from, for example, the biochemical or the psychodynamic; and also it involves heuristically the notion of adaptation, as distinct from such similar notions as resultant of forces or equilibrium of systems. Life style adaptation may be relevant as cause, concomitant, constituent, or consequence of some entity of disorder.

A classification by life style adaptation, specifically applicable to drug users, has been evolved from a study using an instrument similar to the one presented here, and is described in a later section.

The present instrument is divided into three parts: Part I covers material on demographic description, health and disorders, complaints, and utilizations of professional help; Part II covers the focal area—that is, substance use—and other areas that are approached in relation to the focus; Part III, which like the first part is general in its applicability, covers life style adaptation, and includes standard demographic measures. (Response codes, card column arrangements, etc., have been organized to facilitate computer processing; such mechanical features of the instrument design, however, will not be discussed here.)

Every query requires a response to be placed at a specific place and in a specific form. Four different response forms may be distinguished:

(1) *Precoded.* The response is entered by circling a code number which stands for a response category. The category always appears either above or to the right of the number by which it is coded.

(2) *Clear-coded.* The response is always numerical; it is entered by writing the numbers on dashed underlines.

(3) *Uncoded.* The response is brief, usually a word or two or a number, and is entered on a dotted line.

(4) *Unstructured.* The response is discursive. It is entered in the blank space following the query.

ADMINISTRATION OF THE INTERVIEW

Considerable care has been taken in the design of the instrument to facilitate attention, interest, and cooperation on the part of the respondent. Pacing is an important consideration here, and precoded questions which can be answered simply and quickly are alternated with open-end questions requiring a narrative answer. There are, of course, internal devices for determining consistency; but rather than relying on repetition of questions in different forms to insure reliability, emphasis is on the sequential arrangement of questions which allows a "story" to emerge from a series of individual and relatively nonthreatening responses. A great many questions are concerned with matters of "vital statistics," and in fact will appear to the respondent to be very flat and usual.

Since the instrument is intended primarily to investigate positions, associations, attitudes, practices, and episodes, there is little direct concern for measuring such things as motivation or insight (formally, for example, there are only three questions in which the respondent is asked "Why?"). Another reason for the instrument's nonresemblance to a psychiatric interview is the fact that it was designed for administration by an individual *trained in its use,* regardless of that person's background or usual discipline.

The interview schedule is designed for face to face administration by one interviewer to one respondent in one continuous session. As introduction, the respondent is told that the information he gives is respected as confidential and will not be released without his written permission.

The respondent is told that it is the interviewer's job to obtain (rather than act upon) data which will be subsequently considered by a transdisciplinary staff (either to formulate an individual plan for intervention or to be used as part of a research study). The respondent is informed that he is not the only target in the community mental health approach; he is told that research is an integral part of the program and thus all people are asked the same series of questions. Some, therefore, may seem to be peculiar or irrelevant, but they are asked of everyone.

The interviewer's interested but neutral and nonjudgmental attitude facilitates sharing of information by the respondent. Probes, when used, are noninterpretative, consisting either of repeating the respondents own words back to him in a request for clarification, or of neutral phrases like "anything else?" or "what is that?" Every attempt is made to establish rapport with the respondent and to allow him to see that the data he furnishes is useful.

INDIVIDUAL PROFILES

Implicit in community mental health diagnosis is the hypothesis that there is a close interrelationship among community stereotypes and attitudes toward drug users, public policies relating to drug users, scientific attempts to classify and treat drug users, and the actual social characteristics and behavior of drug users. This is the interacting process (or pathology) which provides the presenting problem for diagnosis.

Reference was made in the first two chapters to the nature of the historical changes in the presumed stereotypes of drug users. The major policy change relating to drug users in this country—the shift from a medically oriented policy to a police oriented policy, and recently back to a medical orientation in a punitive context—was also cited. And some attempts to classify addicts were described. It was noted that changes in the social characteristics and behavior of groups of drug users have occurred; it is the aim of a community mental health diagnosis to better understand these characteristics in relationship to the social and cultural milieu. It is our contention that attempts to simplify the problem by reduction to a "key" method of treatment or control (and methods range from incarceration to maintenance) generally devolve from thinking in stereotypes. If the drug user is to be dealt with on the individual level, he must be examined as an individual. That is, drug users must be treated like people and considered on the basis of characteristics which they actually possess.

In order to determine these characteristics and assemble them into legible, descriptive profiles, related data gathered with the screening instrument are grouped and summarized. Examples of this diagnostic and evaluative technique follow.

Two kinds of evaluation may be distinguished: "onsight" evaluation in which a baseline is obvious, and comparative evaluation in which the baseline is group-related and initially unclear.

For onsight evaluation no control group is necessary, because it is already known what will happen under various circumstances. It is likely that hydrophobia, untreated, will result in death; thus the individual bitten by a rabid animal has a clear future which is largely dependent upon whether or not he receives medical attention. Likewise, an individual with a severe drinking problem who has suffered liver damage is in jeopardy and the nature of the risk from continued drinking is evident. Someone with a broken leg, or a limited verbal ability, or hepatitis is clearly disabled.

The individual may possess physical, mental, or social characteristics, the functional or dysfunctional significance of which is obvious and does not require special research for evaluation. In addition, some descriptive demographic characteristics such as age, race, and level of education (which are not "abnormal" like the ones above) are also subject to onsight evaluation. In the individual profile, factors of this kind have only to be described; the description itself serves, practically, as the diagnosis.

On the other hand, many characteristics of the individual and his milieu are not subject to onsight evaluation, but must be considered comparatively. For instance, it is by no means certain that economic poverty, or nonintactness of family, or self-medication with narcotics are in themselves necessarily predictors or concomitants of dysfunction. In order to allow systematic judgment of an individual's condition in areas like this, his relative position in a continuum has to be determined.

This can be done by comparing a score of some kind in a given area with scores of a matched control group to determine direction and degree of deviation from the norm, or by relating the score as a rank-order designation to other individuals in the same rank-order category, thereby classifying the individual as being like those others in terms of the shared characteristic. Prior controlled studies of the significance of the particular variable may allow a diagnostic assessment of the meaning of the individual's position with regard to the characteristic under consideration, which in turn facilitates the charting of a relevant course of action.

Scores may be simple—in which case instances or types are counted, or weighted, with quality or degree taken into account.

A simple score with regard to geographic mobility could be the number of residences the individual has had over the last 5 years. In addition a weighting could be introduced into the consideration of mobility by assigning multipliers to neighborhoods on the basis of socioeconomic characteristics. A simple score for the individual's housing itself might be obtained in the form of a fraction, with the number of rooms as the numerator and the number of people living in them as the denominator.

Another simple score could be obtained from the number of membership organizations to which the individual belongs. Weighting could be introduced by assigning variable value by extent of participation; the score would then reflect, for instance, whether the individual was an officer of the organization or if his active membership extended over a considerable period of time.

An example of a composite index can be found in the development of a criminality measurement score. In a recent study of addict inpatients (this study is discussed further in appendix D), a series of instruments similar to the one in appendix B were used to develop a fourfold life style adaptation typology using conventionality and criminality as the two major variables.

A composite index of conventionality was constructed, based on ranking on five separate indexes of conventional involvement including the areas of work, family, friends, normal-life, and leisure-time activities.

Each person was also ranked high or low, based on median splits, on two separate indexes of criminality, which were then combined into a "composite index of criminality at time of admission" to the hospital. The content of these indexes of criminal involvement is indicated below:

A. *Recent Criminal Acts,* indicating the incidence of criminal type acts recently engaged in to support habit (possession and use of narcotics was not included, being common to the entire population under study), with weighted values given to individual acts depending on the required degree of involvement with a criminal network.

B. *Criminal-Social Relationships,* indicating a composite score for the number of friends or associates whose present or usual occupation is criminal and those with whom respondent engaged in joint criminal activity.

C. *Composite Index of Criminality at Time of Admission,* indicating a composite of the scores on the above indexes; resulting totals ranged from zero to nineteen, and were divided into high and low scores on the basis of a median split.

The example cited is a relatively simple one (it can be seen that the composite index of conventionality would be more complex, since it contains many more elements). More finely graduated scales utilizing this same data on criminality are, of course, possible: the gross division into high and low could be elaborated into a scale with as many as 20 points.

Individual drug use patterns are an example of the kind of data that do not lend themselves satisfactorily to reduction to points on a rank-ordered scale. The drug use profile contains too many kinds of variables in several different though interrelated dimensions to admit simplification to a single score. Thus this kind of data can best be presented in a way which allows several factors to be considered simultaneously. The diagnostic evaluation in one area then takes the form "X, together with Y and Z, indicates . . ." (the three variables in the drug use pattern would be types of drugs, frequency of use, and amount used). This, in miniature, is the general diagnostic approach to the entire profile; consideration of the total picture, area by related area, brings to focus specific functions and dysfunctions.

Whether or not drug use, per se, is dysfunctional is certainly open to question. When medication is prescribed by a physician, its use is considered in a favorable light. When medication is self-prescribed, its use may in no way interfere with the individual's physical, social, or moral functioning—in fact, there may be an improvement. However, external factors are also involved in the form of laws and community attitudes, some appropriate and useful, some not.

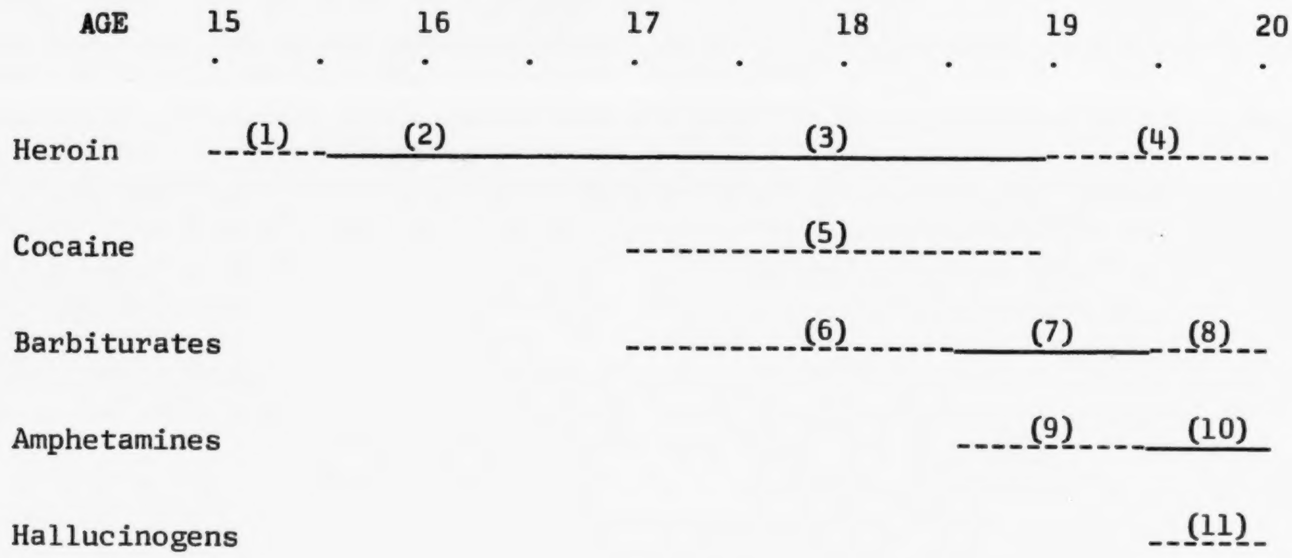
The situation is much like the one which might result if walking barefoot were outlawed and publicly despised because it was thought to make the individual unable to care for himself or contribute toward accepted community goals. Associated "dysfunctions" would be of two types: internal (medical problems associated with stepping on rusty nails, etc.), and external (problems associated with having one's toes stepped on, not being acceptable to polite society, etc.). The extent of the dysfunction might be controlled by where the person engaged in the activity, how often he did it (tolerance could develop to broken glass, for instance, through toughening of the soles of the feet), to what extent it was also common or accepted among his associates, or the degree to which it represented a way of life to the exclusion of other activities. All these factors would have to be examined in order to determine just what significance the activity had in the life of the individual and his community.

Likewise, we look at these same kinds of things in assessing an individual's drug use profile for dysfunctional aspects and possible modalities of treatment. The example which follows (chart II) is not meant to be a typical drug use profile; there is no such thing. It is meant to present, graphically, data on type, frequency, and amount of drug use for one 20-year-old individual through his 5-year drug use history in order to show *how* that data could be gathered with a screening instrument and organized for evaluation.

The individual's age runs across the top of the chart; drugs used are listed on the left. Dotted lines indicate intermittent use; solid lines indicate regular use. Figures in parentheses refer to frequency and amount data which are presented under the chart for want of space on the chart itself.

The drug use chart is given here only as an example of a data presentation technique. Reference to this particular chart will be made later, when the use to which these kinds of data making

CHART II



(1) Snorting heroin; to an average of 1-2 bags a week;
(2) Skinpopping; to an average of 1 bag a day;
(3) Mainlining; habit varies between 2 and 5 bags a week;
(4) Mainlining; about 2-3 bags a week.

(5) Snorting 1 cap of cocaine at a time, about once every 2 weeks.

(6) Two capsules at a time (Tuinal or Seconal), once or twice a day;
(7) Increasing dosage up to 12-15 **capsules** a day;
(8) Occasional use.

(9) Occasional use (Biamphetamine); habit increasing to 3-4 capsules daily;
(10) Six capsules at a time, 3-4 times a day; sometimes combined with codeine cough syrup.

(11) Occasional use (LSD), perhaps once a month.

up the individual profile (from simple scores and descriptions to more complex charts) can be put in diagnosis, and prescription of individual treatment is discussed.

THE INTERVENTION SEQUENCE

Having gathered data and arranged it into a legible format as just described, the first two steps in the five-step community mental health intervention sequence have been taken. The complete sequence consists of (1) inquiry, (2) analysis, (3) planning, (4) treatment, and (5) community action. Each step will be discussed separately.

If the immediate aim of intervention is not individual service, but is, for instance, survey research, steps (3) and (4) will not occur in the order given. In fact, ideally they may not have to be taken at all—if research leads to effective community action to prevent a problem from arising, thus eliminating the need to treat it. In case the problem does not immediately disappear, however, conclusions from survey research can make steps (3) and (4) more effective or can modify the milieu in which they are taken; an example of survey research procedure is outlined in the second part of this section, together with some particular findings with action implications. First, we will consider the procedural constituents of the individual intervention sequence. Specific methods and goals of treatment will be the subject of the next chapter.

INDIVIDUAL INTERVENTION

(1) Data gathered in the *inquiry* step includes information obtained from the referring agency, if the referral has come from an institutional source; information obtained from the individual himself, in the manner previously discussed; and collateral information obtained from other organizations with which the individual has had contact (social service or law enforcement agencies, employers, hospitals, etc.).

(2) *Analysis* characterizes the second step, in that it is "an examination to distinguish component parts separately or in their relation to the whole." Diagnosis starts by structuring component parts. The style of this structuring is partly dependent upon the manner in which the data is gathered; when an instrument like the one considered previously is used as a formal aid to systematic judgment, the structuring becomes largely a prearranged, mechanical matter.

(3) In the third step, data leads to action through presentation (summary, delivery, and discussion), decision, and assignment. This *planning* is commonly accomplished through the vehicle of staff conference. Data can be presented to a transdisciplinary team in summary form (broader views and productive cross-fertilization result when specialists from several fields together consider data touching on the many different areas covered in the inquiry phase). This summary may be narrative, it may be purely in the form of scores and charts, or it may combine the two. Frequently, diagnosis and prescription are open to discussion; as evaluative techniques become more refined, however, intuition comes to be supplanted by various replicable, systemized judgments of the overall situation, and discussion centers on individual modifications.

When a diagnosis has been arrived at and appropriate methods of dealing with it are determined, an agent for coordinating and carrying out this plan is selected. Usually a central case manager should be assigned to coordinate activity; sometimes a single agency specializing in treating the primary dysfunction can handle the case, given supportive consultation on specific drug-related aspects.

(4) Active individual *treatment* begins with establishment of a continuum of responsibility for the realization of the phased plan of action. Analysis of individual profiles of strengths and dysfunctions will have allowed designation of areas of greater risk to the individual and the community, and immediate crisis intervention may be called for. In other areas, longer term adjustment and repair will be undertaken.

The second, and complementary, activity in treatment is periodic evaluation of the consequences of intervention. This is vitally necessary to determine progress, at the time of each followup evaluation, toward stated goals, and to determine different or additional areas for intervention in the ongoing course of treatment.

(5) In the earlier discussion of the etiology of addiction, the importance of factors in the "outer circle" was emphasized. These factors are obviously involved in the mobilization of interactive systems of care for the individual, but they can also be affected less directly as the person is worked with individually, for when one individual is helped, others are likely to benefit also. That is, *community action* can result even if it is not the primary goal, just as improvement in individual situations can result when intervention on the organizational level is undertaken.

Any observed sequence of actions, such as the community mental health intervention sequence, has a data output which can be used for process evaluation or training. In addition, the presence of a role model for coping with addiction serves as a catalyst, and cumulative experience with rational and replicable treatment methods may lead to general positive change throughout the community by modifying punitive or despairing attitudes.

A study of community mental health factors in a treatment program is discussed in the next section, with emphasis on implications for community action.

SURVEY RESEARCH

Because drug use has become a political problem, it is considered advantageous by various public and private figures to address themselves to programs for addicts which have, as primary goals, the enhancement of the public image of these particular figures as reflected in their ability to spot problems, then "get the job done." Inherent in this political approach is the economic reality of drug use. Thus, it is important to understand that there are powerful forces at work in the community which, in effect, tend to frustrate, limit, and restrict the potential for developing effective programs.

In order to study this situation, the Health Research Council of the City of New York granted funds to the Department of Psychiatry of New York Medical College in 1962 to study staff and patients of the narcotics addiction wards at Metropolitan Hospital, an 1,100-bed municipal general hospital at First Avenue and 98th Street in New York's East Harlem. The Department's Division of Community Mental Health was responsible for the 3-year study and the resulting report is titled "Continuities and Discontinuities in the Process of Patient Care for Narcotic Addicts." [33]

The introduction to the report states:

> Too much research in this field has concentrated on the characteristics of individual addicts to the exclusion of key aspects of the problem which lie outside the addict. . . . Research has been too narrowly conceptualized around the individual addict to produce significant innovations in community action . . . The theoretical orientation (which gave rise to this study) is the view that the type and rate of social deviation is to a significant degree a resultant of social and cultural factors. This orientation does not exclude the possible role of psychogenic variables in the etiology of addiction in individuals. The sociocultural focus is more relevant, however, to understanding addiction as a community mental health problem . . . Within this general concern with the impact on addicts of community factors external to the individual, our orientation has included a specific awareness of the possibility that hospital treatment programs and staff behavior as well as laws and public opinion constitute identifiable environmental conditions which may, in certain respects, either ameliorate or exacerbate the problem of addiction. In other words, a focus on social origins of deviant behavior can be broad enough to include consideration of social determinants of the seriousness of the addiction problem among persons already addicted as well as of social determinants of the onset of addiction among persons not yet addicted.

The research design included a longitudinal study of a sample of drug users as they went into, through, and out of the Metropolitan Hospital program; also included was a cross-sectional study of different groups of patients and hospital staff in interaction. Particular attention was paid to the effects of a drug user's experiences with the community before and after his hospitalization on his pattern of drug use or abstinence.

A goal of 250 patients, comprising the study sample, was established, and a 50 percent sample of all admissions to the two 25-bed narcotics wards was decided on. The sample was stratified on the basis of order of admission (even admissions one day, odd the next) and by season, approximately a quarter of the sample being drawn from each season from the summer of 1962 through the spring of 1963. Altogether 253 male patients (all, incidentally, were voluntary admissions—Metropolitan does not take court referrals) entered the sample. The authors are careful to note that the sample is not representative of *all* drug users, but only representative of those entering Metropolitan Hospital. Thus, care should be taken in generalizing the results of the study. In addition, 33 staff members, 61 percent of the total, were studied.

Patients and staff were interviewed, using one or more of six instruments similar to the one included in appendix B. Also taken into account were participant observations by research staff and hospital records and program materials. The instruments were administered, in the case of staff, midway in the one year data-collection phase, and in the case of patients, at various times during the process of interaction with the hospital—on admission, during stay on the ward, on sign-out, after several months back in the community, etc. Questions to staff were mainly concerned with attitudes towards drug users and addiction, reasons for working on the narcotics wards, and expectations about the program and its goals. Patients were questioned on nearly everything that could have a bearing on their lives, from background information on ethnicity, religion, age, and family circumstances, through expectations about their future lives in the community. Altogether, more than 360,000 items of information were collected from staff and patients.

A special problem in obtaining valid and reliable information from drug users was presented by the fact that the cultural context within which addicts are viewed by others and within which they view themselves is more highly ambivalent and changing than the context within which most subjects of research are viewed. As the report states:

> Even in the hospital, addicts are frequently suspicious of nonaddicts, sometimes very cooperative, sometimes friendly and talkative,

> frequently sensitive, and sometimes withdrawn and reticent. These various attitudes are often held not only by different addicts, but by the same addict at the same time, as well as at different times.

The approach which the research staff developed to overcome the patients' resistance and tendency to give unreliable information was ". . . to stress our disattachment from the service function fulfilled by the other staff members and (emphasize) our noninvolvement in the direct process of producing change in individuals. We have defined our role as researchers as a *nonservice* one in which a concern with improving services for addicts generally is translated into action by the collection of *confidential* data from patients and staff bearing on subproblems which we believe have important action implications. When asked, we indicated that it was not our purpose to help individual patients with their problems nor were we professionally concerned with getting patients to stay off drugs or change in any other way after they leave the hospital . . . Both to protect the addicts from any possible repercussions either from law enforcement agencies or from hospital personnel and to earn the trust of the addicts, procedures were carefully worked out which insured the strictest confidentiality with regard to the data obtained."

The data were coded, punched into IBM cards, and processed by computer. It was thus possible to cross-tabulate a great number of variables against one another. For example, the relationship between age of onset of addiction and size of habit could be determined, keeping chronological age or type of drug used or ethnicity constant. The basic analytical technique, then, was the systematic comparison of various subgroups with regard to a wide range of characteristics, attitudes, and behavior. Because a computer was used for these cross-tabulations, it was possible to test for the presence of a great variety of factors which might lead to spurious conclusions. For instance, on finding that those patients who had been out of the hospital longer tended to be more optimistic, it was possible to test for a spurious factor by controlling for whether they had a job or not, and whether it was this fact that made them optimistic, not the actual length of time away from the hospital.

The main direction of the study was toward the establishment of a social typology of drug users, reflecting their modes of adaptation to the community environment, that is, their life style adaptation. In this case, the life style adaptation typology was a two dimensional one, involving criminality and conventionality as major variables. The combination of an individual's involvement with conventional activities and his involvement with criminal activities determines his life style adaptation. It is stressed that conventionality and criminality are in fact *two* variables, not opposite ends of one variable. In other words, just because a drug user is highly involved with criminal activities does not necessarily mean that he is uninvolved with conventional ones (as the popular stereotype would depict him). The dimensions of conventionality and deviance are thus conceptually independent. As a matter of fact, drug users were found who were highly involved in both worlds; and users were found who were very little involved in either. So the life style adaptation typology emerges as a fourfold one.

As shown in chart III, names were given to the four types: *conformist,* to the individual highly involved in conventional life and not significantly involved in criminal life; *hustler,* to the individual highly involved in criminal life and not significantly involved in conventional life; *two-worlder,* to the individual highly involved in both areas of life; and *uninvolved,* to the individual not significantly involved in either area.

Case histories representing each type—conformist, hustler, two-worlder, and uninvolved—are given in appendix C.

Composite indexes of conventionality and criminality were constructed on the basis of answers to many questions on work, family, friends, leisure activities, recent criminal acts, and criminal-social relationships. In this way, the individual's typology just prior to admission to the hospital was determined. Many more variables were then tested against the individual's typology, and their relation to that typology evaluated. For instance, it was found that 60 percent of the conformists had worked at least half the time since they became addicted, while only 18 percent of the hustlers had done so. And 76 percent of the conformists were influenced in their decision to come to the hospital by talking to someone they respected, while only 50 percent of the uninvolved were so influenced. (Neither of these items was used originally to determine the individual's typology.)

Some of the findings of the study, sometimes on the basis of differences between the adaptations,

CHART III

		CONVENTIONALITY	
		High	Low
CRIMINALITY	Low	Conformist	Uninvolved
	High	Two-Worlder	Hustler

and sometimes on the basis of the addict population as a whole, follow:

The average addict in the sample first heard of drugs at 16 (many had heard of drugs at a younger age, of course), first tried drugs at 17, and became addicted at 18.

The addicts in the Metropolitan sample were 39 percent Puerto Rican, 36 percent Negro, and 24 percent white. (In these and subsequent percentages, the total may not be quite 100 percent due to the presence of a few percentage points of "Others.") Interestingly enough, conformists were most likely to be found not among the whites, but among Negroes.

58 percent were Catholic, 35 percent Protestant, 4 percent Jewish, 1 percent Greek Orthodox, and 2 percent grew up without any religious affiliation.

The median age of the sample was 25 years, with a range from 14 to 74. 56 percent were between 21 and 30; 20 percent were under 21.

The median school grade completed was the 9th grade; however, 61 percent had some high school, 18 percent were high school graduates, 4 percent (11 patients) had some college, and 3 of these obtained a degree. Conformists tended to be included in the group that had had most schooling *and* in the group which *had never gone beyond elementary school.*

70 percent reported that their father was a blue collar worker.

Of the addicts who had both parents living, whites were much more likely (74 percent) to report them as living together than were Puerto Ricans (53 percent) and Negroes (48 percent). The authors hypothesize that this may in part be due to the tendency of low income minority groups with a rural background (i.e., the Negroes) or of recent migration into a culture and economy which places in sharp conflict traditional husband-wife relationships (i.e., the Puerto Ricans) to contain a disproportionate number of families with fathers absent.

Just over half of the sample were single at time of admission; of the 47 percent who had been married at some time, 30 percent were still married.

Over a fifth of the sample were diagnosed by the intake psychiatrist at the hospital as having no personality disturbance other than "drug addiction." Of all cases, 83 percent were

> diagnosed as having personality disorders and 13 percent as schizophrenic reactions.
>
> All but seven addicts reported that heroin was the drug they used most often; amount used ranged from less than one $5 bag a day to one addict who reported using sixteen $5 bags a day; the average was 3–4 bags a day.
>
> The median length of addiction of patients was just over 5 years. The range was from several months of addiction to 48 years. The median number of previous detoxifications (that is, the number of times they had "kicked the habit") was five.
>
> Conformists tend to show up among the youngest and the oldest addicts. Over the years, the addict is likely to move from a conformist adaptation, to a two-worlder one, to a hustler, to uninvolved, and back to conformist.
>
> Half the conformists had never been in reform school or jail, but only 12 percent of the hustlers had managed to stay out; in all, about three-quarters of the addicts had been in jail or reform school.
>
> Three-quarters of the conformists and half the hustlers think that heroin hurts the body more than alcohol (in fact it does not).
>
> 26 percent of the conformists say they are ashamed of using drugs; none of the uninvolved are ashamed; in all, fewer than 10 percent of the addicts say they are ashamed of drug use.
>
> And finally, 63 percent of the conformists claim that their neighbors do not know of their habit, while 71 percent of the hustlers' neighbors *do* know.

It is of first importance to realize that the primary implication of the research data is that there are, sociologically, different *kinds* of drug users.

One of the most significant aspects of the study involved the determination of what the individual really desired when he came to the hospital. Did he want, for example, only to reduce his habit from $50 a day to something he could afford? Or did he have other goals as well?

> Patients were asked directly what they wanted the hospital to do for them. Four-fifths responded dominantly in terms of "breaking my habit," "helping me kick," "curing," or "withdrawing me." Eight percent stated rehabilitation or a change in way of life as their main goal; 7 percent hoped most for therapy, insight, or psychiatric change. This major emphasis on drugs—detoxification and/or abstinence—rather than on rehabilitation or change or even on therapy, suggests that these reasons are not totally rationalizations but in part reflect real reasons.
>
> We know from other observations that the relative emphasis is about right. There is a semantic confusion, however, which has become traditional in the treatment of drug addiction. The confusion is in the meaning of such terms as "break the habit" and "take the cure." On the surface, these terms imply ending or at least trying to end addiction. However, they have come to denote detoxification (that is, immediate withdrawal from dependence on the drug, without any long range implication for continued abstinence), at least for many addicts.
>
> Even among staff, these terms are frequently understood in the way addicts operationally use them; yet staff are not quite so ready to give up the distinction between stopping the habit and slowing the habit down.
>
> It is this discrepancy between the addict's *de facto* dilution of these terms and the tendency of the community and its caretakers to adhere to the *de jure* purity of the terms that cautions us against accepting the above statements as more than rationalizations as to what patients wanted from the hospital. We would not be justified, in other words, in equating the addicts' stated goal of "cure" or "breaking the habit" with the goal of abstaining from drugs indefinitely.

And so, many different questions, some direct and some very indirect, were asked in an attempt to ascertain what the individual *really* wanted the hospital to do for him.

> We were able to break down the blanket category of "break the habit, help me kick, or cure me" into two major groups: those who wanted to "get off" drugs and those who wanted to "stay off" drugs as a result of the hospital's efforts. Getting off is used here as a crude index of the addict's definition of "cure" and staying off as a crude measure of staff's definition of "cure."
>
> Of the total sample, 70 percent mentioned getting off drugs as a major goal, and 20 percent mentioned staying off as a major goal.

> The remaining 10 percent said they wanted social and/or psychiatric change only.
>
> The evidence is considerable that the basic motives underlying the reason for hospitalization given by most conformists, as well as by most addicts adapting in other ways, do not include the goal of ending the habit. Additional findings which lead to the conclusion that other motives are predominant appear in almost every aspect of our studies. . . .
>
> The adjustment of patients while in the hospital also suggests the operation of primary motives other than the desire to learn how to live without drugs. The fact that a majority of addicts sign out of the hospital without waiting for the completion of the recommended treatment period is a case in point. . . .
>
> Nevertheless, the possibility is clear that habit reduction can be sought as a means of achieving a desirable change in adaptation. Although most patients seem to want detoxification only as a means of adjusting to some momentary pressure, some appear to want to change their adaptation while continuing their addiction. Others may be groping toward formulating for themselves a goal of improved adaptation, but lack the outside support necessary to arrive at such a conception.

Because the drug user generally does not share the community's overriding moralistic concern with abstinence from drugs, the individual and the community are unable to cooperate in moving toward mutually satisfying and beneficial goals. The report states:

> The community takes comfort in the illusion of treatment. Hospital beds, in particular, are tangible and have an aura of medical accomplishment. But current hospital goals for treating addicts are implicitly if not explicitly aimed at abstinence from drugs or removal of addiction in the case of every patient, without exception. This is true even though no reliable cure for addiction has yet been identified. This exclusive and obsessive concern with abstinence is not only frustrating for both staff and patient alike but it militates against the possibility of helping the addict with the very real problems he has in coping with his environment. . . . As with heart, cancer, and other chronically afflicted patients, the content of the therapeutic interchange with addicts should not be diverted and defeated by an underlying obsession with complete remission or cure.

INTERACTING RESULTS

Whether the immediate aim is individual intervention or survey research, the same initial technique is used in the community mental health approach: individuals are studied with structured instruments to obtain objectively evaluable data. Survey research discloses relevant variables in the problem situation under study. And results of the study inform individual and community intervention techniques. Ongoing intervention is also studied in like manner and evaluated for effectiveness, so that resulting followup information may be fed back and the process amended where indicated. The individual case is thus continually weighed against hypotheses and findings regarding a larger population, and individual problems are seen in relation to the overall community situation. In this way the fourth and fifth areas in the intervention sequence, case treatment and community action, illuminate and reinforce each other.

In community mental health practice, the situation is similar to the one described by Paul Lemkau concerning epidemiological methods in psychiatry:

> . . . most of the hypotheses to be tested by epidemiological methods originate in clinical studies. On the other hand, if we are to reach any justifiable generalizations in our field, we shall certainly be dependent upon some techniques for testing hypotheses against a larger population than a single case. To be sure in the process some truths about individuals will be lost, but by complementing individual studies, these population investigations will give us a better grasp of the factors in human living that can be changed for the betterment of the mental health of all men.[26]

IV. TARGETS, GOALS, AND METHODS FOR INTERVENTION

The previous chapter dealt with a diagnostic activity and some objects of that activity, but deliberately omitted discussion of the performing agent. This was done to emphasize the fact that a community mental health *approach* is an attitude, a way of doing business, that may be utilized in a wide variety of settings by a wide variety of agents facing a wide variety of problems. The performing agent may make use of community mental health techniques of diagnosis and intervention in settings as diverse as social welfare, religious, public assistance, or law enforcement organizations, whose obvious primary concern is not "mental health." It is, in fact, our hope that such use will be made of these techniques outside the specific area of drug dependence now under consideration.

Since the passage of the Federal Community Mental Health Centers Act in 1963, the concept has evolved of a specialized organization, or performing agent, whose primary activity would be the demonstration of community mental health practice rather than, say, the distribution of money or the enforcement of laws. Given a community mental health view of drug dependence, which recognizes the importance of all those interacting community and individual variables we have mentioned, the specialized community mental health organization would be structured in such a way to allow it to deal effectively with these interacting variables. A simplified schematic representation of the action-research design of such an organization follows, as chart IV.

Although such community mental health centers are now in existence, it is not with their function as specialized agencies that we are presently concerned. It is, rather, with the general applicability of the developing activity and the accumulating body of knowledge; while hospitals are institutional centers of activity relating to physical health, the body of knowledge on this subject is taken advantage of in many ways throughout the community. Our concern is to make community mental health practice equally accessible.

Therefore, the question of exactly *whose* goals and methods or prevention, control, and rehabilitation are now being considered is not of primary importance. What is important is the style of an activity which can be used in many different circumstances. One distinguishing characteristic of this community mental health practice is that action, research, and training bridge four levels, from the individual, through the interactional and organizational, to the institutional. Chart V gives examples of targets in each area at each level.

Wherever one's primary interest lies, consideration must also be given to factors generated in other cells. Individual treatment of the drug user, for example, is influenced by the public's image of the drug user, as has been discussed previously.

Community mental health service directed toward individuals generally takes the form of "treatment." Such treatment on or for individuals is also *for* the community. Conversely, work with organizational and institutional forces is also *for* the individual, whose functional condition is liable to improve as his environment becomes more viable.

CHART IV

ACTION RESEARCH DESIGN OF A COMMUNITY MENTAL HEALTH PROGRAM FOCUSED ON DRUG USE

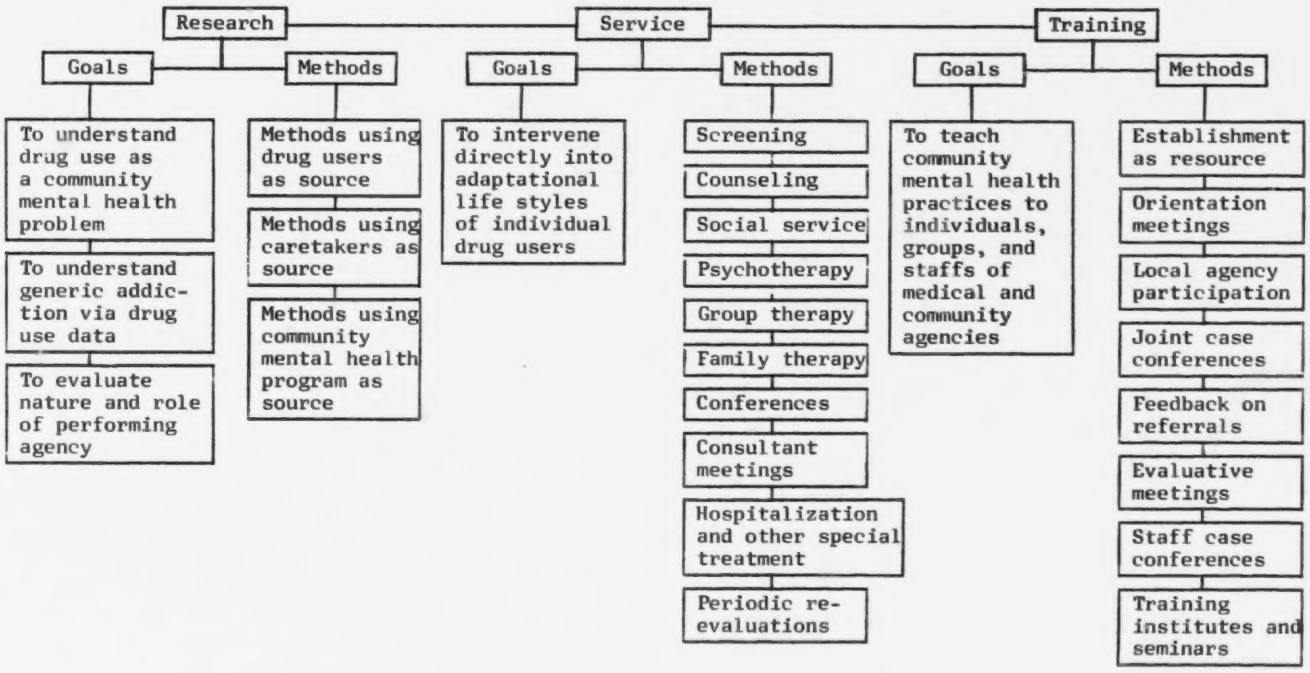

Research
Service
Training
Goals
Methods
Goals
Methods
Goals
Methods
To understand drug use as a community mental health problem
To understand generic addiction via drug use data
To evaluate nature and role of performing agency
Methods using drug users as source
Methods using caretakers as source
Methods using community mental health program as source
To intervene directly into adaptational life styles of individual drug users
Screening
Counseling
Social service
Psychotherapy
Group therapy
Family therapy
Conferences
Consultant meetings
Hospitalization and other special treatment
Periodic re-evaluations
To teach community mental health practices to individuals, groups, and staffs of medical and community agencies
Establishment as resource
Orientation meetings
Local agency participation
Joint case conferences
Feedback on referrals
Evaluative meetings
Staff case conferences
Training institutes and seminars

CHART V

ROLE-CONTENT MATRIX OF COMMUNITY MENTAL HEALTH ACTIVITIES RELATED TO DRUG USE

LEVEL OF ORGANIZATION

OBJECTIVE	Individual	Interactional	Organizational	Institutional
Service	Drug user	Drug user relating to his family	Housing Dept. policies	Public's image of drug addicts
Training	Medical student	Resident treating drug user	Hospital admitting drug user	Professional image of addict
Research	One subject [via psychological test]	Married pair [via symbolic interactionist study]	Treatment program [via operations research]	Statuses, values and attitudes [via survey research]

AN ENVIRONMENT FOR REHABILITATION

Under present conditions, drug use is a critically limiting factor in any attempt toward individual social rehabilitation. In spite of the fact that drug use, per se, may be only a symptomatic or peripheral difficulty, the individual user falls into a situation so chaotic and dangerous that until that situation itself is changed, any reconstructive activity occurring within it is subject to an extraordinarily destructive ambient interference.

In a few cases, brain surgery may be successfully performed on a battlefield; admittedly, the chances for the patient to recover are slight. Normally, such a delicate operation would only be considered under far more favorable circumstances. To remove the procedure from the mud and bullets is a first step.

Social rehabilitation is a delicate and complex operation, and we have little expectation for its success under circumstances of siege. To describe the interaction of the elements presented in chart I in war terms is an overstatement inasmuch as it implies logical advance planning by opposing sides, but it seems quite appropriate for description of the style of the ongoing activity. To reduce tension in this situation, to call a truce, to allow the participants to stop harassing each other long enough to begin to behave rationally—all these are preconditions for reconstruction and rehabilitation.

One method which is receiving increased attention for actualizing this truce is the regular administration to drug users, under medical control, of a narcotic drug, usually methadone. This has the immediate effect in a great many cases of removing the drug user from the "cops and robbers" game, and making him more accessible for evaluation and appropriate treatment.

In all the subsequent discussions of individual goals and methods, it must be assumed that the environment in which rehabilitation is to take place is such that the chaos surrounding drug use itself has been reduced (and some methods for doing this are at hand) from the level that is presently typical.

GENERAL GOALS IN INDIVIDUAL TREATMENT

In order to establish more specific goals for treatment than that of "improved functioning" in general, it is necessary to locate major areas of dysfunction and to measure levels of dysfunction in each area. This approach is unconventional, with regard to the drug user, only in the sense that it rejects the antitherapeutic biases of present punitive and moralistic approaches. Our concentration of effort is on treatment of the drug user as one who needs help in handling problems associated with a chronic condition; and treatment goals can be developed for drug dependence analogous to therapeutic goals for other chronic conditions. Improved adaptation or functioning then becomes the core goal of treatment, with particular phased subgoals assigned on the basis of individual characteristics.

It has been emphasized that personal characteristics are not necessarily the heart of the matter of drug use. It will be noted that the four major goals listed below do not, in fact, depend on personal characteristics. However, the particular route chosen to arrive at each of these goals is an individual matter, as are the particular implementing techniques chosen.

By measuring the level and nature of social dysfunction in family, work, friendship, and leisure-time aspects of conventional living and in criminal aspects of deviant living, various kinds of adaptational problems may be identified which are crucial in the establishment of realistic treatment goals. In addition to this assessment of social function, a diagnosis of major health problems is necessary. These problems might include malnourishment, a high degree of exposure to hepatitis, tetanus, and other diseases carried by unsterile needles, poor dental health, evidence of brain damage or other consequences of heavy alcohol and barbiturate use, and signs of specific mental disorders.

In addition, the psychiatric diagnosis, together with a consideration of the drug dependent person's age, sex, race, education, occupation, and pattern of drug use, become essential instruments in the selection of adaptational goals and effective methods of achieving them. In cases of gross pathology, treatment of mental illness could take priority over treatment of social adaptation problems. In most cases, however, treatment of the social maladaptation would have priority.

By attaching major importance to the life style classification of social functioning, identification can be made of a variable set of adaptation problems among drug users which are crucial for selecting differential treatment goals. These problems of social adaptation are significantly different from the problems of drugs users which are currently diagnosed and treated.

Specific goals for treatment follow logically from diagnosis of specific areas of dysfunction. To keep a proper perspective, the appropriateness of these goals should be compared, not to present goals in treating addiction, but to accepted goals in treating other chronic medical-social problems.

We can identify major goals at four different levels: (1) improved health and prevention of disease; (2) increased participation in conventional activities; (3) decreased participation in criminal activities; and (4) maximal social functioning and cessation of drug use other than in the treatment of illness.

The following kinds of subgoals relate to improved health and prevention of disease:

a. Establishment of a satisfactory level of general health;
b. Maintenance of good dietary habits and eating patterns;
c. Cure of acute physical illness and conditions;
d. Treatment of chronic physical illness and conditions;
e. Treatment and care of gross mental disturbance when such pathology presents a more immediate problem than does physical condition or social adaptation;
f. Preventive health education in sanitary methods of self-administration of drugs to which the user is liable to relapse;
g. Reduction in use of physically damaging drugs or drugs which lead to violent or dangerous behavior during intoxication;
h. Provision of physical immunity to high risk diseases such as tetanus.

These goals are aimed at improving the drug user's present state of health and at reducing the probability of disease when the individual is not in immediate contact with a treatment institution.

Subgoals for improved social functioning can be divided into two groups. The first group is aimed at increased participation in conventional activities and consists of:

a. Satisfactory performance on a job suited to the individual's skills;
b. Improved family functioning;
c. Satisfying relationships and conventional activities with friends;
d. Satisfying participation in conventional leisure time activities, organizations, and community life;
e. New roles in prevention and treatment of addiction in others.

As in the case of health goals, any number of these goals for reducing social dysfunctions in conventional living, or none of them, may be indicated for a given individual. It may be anticipated that at least one of these goals, in addition to the last one, would be indicated for most drug users who come into contact with care and control organizations. The individual who is a good family man, who has a steady job, who participates in community life, and enjoys normal recreational activities with his friends, however, is in little or no need of help in these areas. His adaptational problem may be exclusively in the realm of criminal involvement.

The second group of subgoals for improved social functioning is aimed at decreased participation in criminal activities. Included are:

a. Reduction of criminal behavior to the point of its elimination;
b. Cessation of criminal activities endangering the life and limb of other persons;
c. Avoidance of activities which directly or indirectly facilitate the addiction of nonaddicted persons.

The last mentioned goal in effect calls for the purposeful utilization of addicts—including the large majority who continue to relapse—as conscious agents of prevention. Their knowledge and recommendations for procedures would obviously be of great value in programming in this and other areas of improving adaptation.

A final goal is that of achieving complete cure of addiction and maximal physical, mental, and social functioning. This comprehensive goal is a combination of the conventional goal of abstinence and the more meaningful goals of minimizing dysfunctional behavior.

Selecting this goal in a given case means, among other things, that an abstinent opiate addict who becomes dependent on alcohol, barbiturates, or other destructive drugs would be considered in no way "cured." His condition would in most cases be evaluated as having worsened.

Moreover, selecting this goal means that abstinence achieved without the desired level of function is rated as a failure of treatment. In contrast, improved health and/or increased conventional, noncriminal adaptation as a drug user are rated as treatment successes when these are the only goals of treatment selected for a given patient at a given time. The crux of the matter, then, is the nature of the specific goals selected.

PATIENT CHARACTERISTICS AND SOME TREATMENT TECHNIQUES

A key question in the selection of treatment goals is that of priorities. Experience indicates that few persons chronically dependent on opiates are ready to abstain and function "normally." To select such a goal routinely or even frequently as is the case today is to court failure and frustration and to help perpetuate self-defeating policies. Abstinence is likely to be indicated as an immediate goal only for a selected few, and for some other addicts to come later in the course of treatment, perhaps after years of rehabilitative effort.

Another reason we have listed the comprehensive goal of abstinence and maximal functioning last is to give prominence to those goals which are not immediately linked to abstinence. It is our firm conviction that in order to achieve the vital goal of improved functioning for increasing numbers of drug users today and ultimately to achieve the goal of functioning without addiction, it is essential to deemphasize abstinence as a *goal* and to see it, rather, as one occasionally indicated *method* of reducing dysfunction.

Our broad medical and social goals are practicable through a wide range of treatment techniques currently available. The problem is in moving beyond the diagnosis of "addiction" to an enumeration of specific points of dysfunction so that these techniques may be seen as being, in fact, applicable to the individual case.

Treatment Rationales in Chronic and Acute Conditions. Much attention has recently been focused on "the poor" as a group having characteristics other than simple lack of financial resources, characteristics which contribute to their relatively unsatisfactory position in modern society. Hardly anyone now proposes that the problem of the underclass (the term is Gunnar Myrdal's) can be significantly relieved just by giving them money, thus removing one sign of poverty. The state of the underclass person is made up of a whole constellation of attributes and situations (a poverty "syndrome") which seems unlikely to be changed just by adding money.

A similar situation obtains with people dependent on narcotics. Singleminded attention to "treating" that one aspect of life-style adaptation by "forbidding" addiction in order to remove one sign of it is like focusing only on the financial situation of the impoverished as a target for change.

Expecting the drug-dependent person to "stop being an addict" by simply abstaining from drugs is like expecting the impoverished person to "stop being poor" by getting a high-paying job: in neither case is the situation entirely under the control of the individual.

In many cases, the use of a program of drug stabilization as the *initial* treatment measure is similar to the use of a negative income tax or a guaranteed annual income to stabilize poor families as a step toward rehabilitation; that is, as a method of providing an atmosphere which will contribute to, rather than detract from, other objective "helping" measures.

Agreement is widespread that the poverty now being attacked on a national basis is a chronic condition among those afflicted, and treatment methods have been chosen accordingly. There is no longer any support for the idea that putting the poor in jail will teach them a lesson and snap them out of their condition. It is recognized that immediate treatment goals and methods generally appropriate to acute disorders are not applicable here.

Still, institutionalization of one kind or another continues to be used against drug-dependent individuals. No matter whether drug-dependence is seen as a chronic social dysfunction, like poverty, or a chronic medical problem ("When a person goes to the hospital for the third time because he has ulcers, do we tell him he has no business in a hospital, that he has to go to jail?"—Isadore Chein), or, as we suggest, a situation including both social and medical elements, any punitive approach is out of place.

On the other hand, drug stabilization has been criticized as mere palliation, when what is really needed is a "cure." Palliation carries a pejorative connotation in acute disorders if the particular treatment is only a smoke-screen displacing more effective immediate action which should be taken instead. However, in chronic conditions, this view of palliation does not really apply. Neither a guaranteed income nor narcotic maintenance are replacements for other effective remedies which ought immediately to be undertaken. Rather, they are techniques through which people are given initial support so that they may then move from "illness" to "health"—that is, to generally more satisfactory levels of functioning—as additional rehabilitation modalities, as needed, are put into operation.

This kind of approach toward reducing dysfunction—initial application of measures designed to reduce discomfort, disorder, and tension—is particularly useful in those conditions for which no unitary cause can be isolated. In diseases where a pathogenic organism is present and identifiable, treatment consists of measures to reduce and eliminate the pathology, together with measures designed to support the patient while this goes on. In chronic conditions, the emphasis is reversed; supportive measures are put into effect, causative factors are investigated (multiple causation seems the rule in drug-dependence), and then discovered causes, either internal or external, are removed when such removal is feasible.

Drug stabilization, then, can serve two major purposes as an initial treatment measure. As previously discussed, it can reduce the anti-therapeutic tension between the drug-dependent individual and his community by reducing the antisocial activity from which the community suffers considerable damage, particularly in terms of property loss. Second, it can support the addicted individual through a rehabilitative process (or, in the case of the already capable individual, allow the capability to be expressed without interference from drug-acquisitory behavior). Thus, not only may socially destructive activity be reduced, but individual socially constructive activity will become possible. In general we can say that any treatment program ought to concentrate on *both* these objectives: the elimination of destructive activity *and* the facilitation of constructive activity.

Implications of the Drug Profile. Given the opportunity, medical science is as generally competent to deal with the physical health problems of drug-dependent persons as those of any other population. Likewise, social work techniques, ranging from family therapy to vocational training, when applied in a reasonable milieu, will have the results that experience with other groups of clients would lead us to expect. Since the present manual is not a primer on casework or medical practice, an enumeration of the many specific social and medical treatment techniques and the problems to which they apply will not be undertaken. However, because knowledge (as opposed to superstition) about drug-dependence seems limited to rather narrow dissemination, and many treatment agents consequently find themselves in the dark when attempting to help a person presenting the seemingly spectacular symptom of addiction, a few considerations on drug use itself will be discussed.

Using the drug profile (chart II) as an example, it is clear that this individual is in serious jeopardy from two distinct sources. First, of course, is the ever-present danger of being arrested for illegal activity. Second is the less obvious, but in the long-run perhaps even more life-threatening, situation represented by the progression of drug use from heroin to barbiturates and amphetamines.

Under present legal conditions, the drug-dependent individual and the treatment agent concerned for him find themselves in an extremely difficult situation: the legal sanctions against heroin involvement are far more severe than those against barbiturate and amphetamine use. But opiates are far less physically damaging than barbiturates or amphetamines—or alcohol.

The higher rate of substance-caused ailments (brain, liver, or kidney damage, toxic psychoses, etc.) associated with the use of other than opiate drugs is the reason we insist that the drug-dependent person who abstains from opiates only to turn to other drugs, specifically alcohol, barbiturates, or amphetamines, cannot be said to be making progress.

The chronological drug profile cited thus represents a progression from external threat to internal threat. The treatment agent who believes that drug abstinence is unrealistic in this case is in a double bind, for to suggest a return to heroin use, which is physically safer, is to advocate an activity which is criminally expensive and extremely risky. In addition, from society's point of view the opiate user is "safer" as a member of the community in terms of the incidence of bizarre, erratic, or dangerous behavior than are users of other drugs.

There is evidence that opiate use tends in a great many cases to be a self-limiting process, and that "maturing out" of opiate use can occur. As Charles Winick notes in "The Epidemiology of Narcotic Use":

> The typical user of opiates uses them for a mean of 8.6 years, although some are known to have been taking drugs for as long as 56 years. The earlier in life drug use begins, the longer it is likely to continue. According to one estimate, for every year that the user delays the onset of drug use, the length of the

> period of drug use is shortened by one-eighth to one-ninth of a year. At any given time, the number of users can thus best be expressed in terms of the number of users at the various stages of the cycle of addiction. A minority (7.25 percent) of the users take opiates for 15 years or more and do not mature out; 15 years appears to be the period beyond which forces that are countervailing to maturing out make themselves felt.[47]

These figures were assembled for *opiate* users. It is unlikely that they are applicable to individuals dependent on additional or other drugs—and a great number of drug dependent persons (a large majority, in our experience) are multiple substance users.

It is clear, however, that the prognosis for abstinence is particularly poor both for those who have been addicted a very long time *and* for those young people who started drug use early. Taken in the context of the individual's life, then, the drug use profile can be one useful indicator of what to expect, both in terms of the trend of future use if left unchecked, and the possibilities for rehabilitation. Particularly for drug-dependent individuals with little present conventional involvement, an early onset of addiction is not an encouraging sign, for the individual will have had little opportunity to develop conventional social and vocational skills upon which to depend for support in rehabilitation.

It is important to consider the drug use profile in context for another reason. It is not necessarily the case that drug use is dysfunctional per se. If drug use does not represent a definite health hazard (opiate use does not) and the individual is able to support that use and integrate it into his social functioning (doctors, nurses, and musicians often do), then the real problem is that there is a law against a "criminal" activity which has no discernible victim. That is, the problem in this case, as in the others discussed, is an interactional one associated with the community's reaction to "deviance."

COMMUNITY ORGANIZATION IN A COMMUNITY MENTAL HEALTH CONTEXT

Contemporary mental health problems require the movement of tradition-bound professions to new levels of integrated understanding, knowledge, analysis, and rational action aimed at treatment and ultimate prevention as the interrelationship of the substantive problems of addictive behavior with the general problems of urban poverty, unemployment, and housing poses a continuing challenge in the planning and development of communitywide action programs. Social planning per se is an established fact today. The major question facing planners in the social health field is "What shall be planned for whom, how, when, and by whom?"

When one thinks of community planning and development, it is natural to associate the practice of community organization with such processes, as this branch of social work has traditionally been concerned with the balance between social need and social resources. The community organization method and process has often been in the forefront of planning activity aimed at increased involvement and participation of agents of service or those being served around increased health and welfare services.

To repeat, targets for organization have been the people being served *or* those providing the service. In the case of organization of clients, the resulting body most often has characteristics of a company union, with "bargaining power" resulting from organized and directed pressure.

Community organization for urban mental health programs ought not to polarize the client and the resource groups any longer. The organization worker in mental health programs faces the immediate problem of *conciliating* the objectives of the persons requiring care and those offering help.

We have discussed some traditional service or treatment approaches to narcotic users, pointing out that these approaches have been limited to the addict and his immediate membership groups (family, friends, employers). These treatment approaches, in other words, have been confined to the individual and, sometimes, interactional levels of the problem in the identification of intervention targets.

That is, the locus of the problem is generally placed within the inner circle of the field presented in chart I. A moment's reflection, however, will show that the *trouble* shows up at the individual-community interface. To borrow a concept from gestalt psychology, there can be no figure without an accompanying ground. There can be no addict without a context in which he is seen and treated as such. We insist, therefore, that attention be paid to both individual *and* community variables as targets for intervention.

To do this requires a transdisciplinary approach. We do not mean that many different kinds of professional people ought to treat the patient (this, incidentally, does seem to be the most common interpretation of the concept "interdisciplinary approach"). Our requirement for interdisciplinary cooperation is based on our contention that many things *other than* the patient need to be treated. There is no doubt that medical professionals are generally competent to deal with "inner circle" disorders. But for intervention in the whole user-environment system, workers whose field of competence is the *community* are also needed; these could include sociologists, educators, politicians, indigenous systems negotiators, and community organizers.

Taking cognizance of the fact that the more subtle elements of the problem come to view as the drug dependent person interacts with a variety of community forces, the community mental health approach seeks out (organizational) treatment agents involved with drug users. These agents may be referring institutions, or they may be potential responsible agents of care for the drug-dependent individual, based upon their own defined organizational function in the community. In setting a treatment and rehabilitation plan for any given patient, one or any number of such functional agents may be selected as vital to the course of treatment.

Having identified agencies for involvement, it is necessary to select a method which might then help to achieve the rehabilitation goals. A most useful technique for determining the feasibility and probable outcome of cooperative agency activity toward rehabilitation goals is the joint case conference. Such a method also helps all parties to understand the nature of the presenting drug dependence problem as the basis for such planning. There is, then, a training function carried by the joint case conference: mutual training in understanding the nature of other agents' functions, attitudes, policies, and limitations; and training about "the addiction problem" as demonstrated in the individual case. The joint case conference is therefore a vehicle for establishing a dialogue around the case of drug dependence involving treatment and training aspects and aimed at specific objectives in both functional areas.

Our departure from the traditional view of the problem of addictive behavior as solely an individual one offers an opportunity for a fresh outlook and the development of creative effort on the part of professional persons concerned with the social health of our communities. Traditionally, professions dealing with these problems have viewed them from their own platforms—the psychiatrist, psychologist, and caseworker seeing them as psychodynamic problems, the sociologist as results of group interaction, the community organizer as targets for coordinated welfare services, and so on. This compartmentalization of professional thought and action stands as an obstacle in the way of progress toward greater understanding of these problems and their ultimate prevention.

Our representation of "the case" as a system of interacting forces offers a view of the functional continuities and/or discontinuities in the individual and environmental forces related to the treatment and rehabilitation of the patient. Targets for intervention will then include patients, family, friends, employers, leisure time organizations, caretaking agents, their personnel, policies, and procedures, all as they relate to the objectives of treatment and rehabilitation.

Viewing a case in this broader sense, "treatment" goals then move beyond those for individual rehabilitation to include objectives for *all* the parties involved, including: (1) improved health and prevention of illness in the individual; (2) satisfying participation in constructive activity, improved functioning with family and friends, satisfying participation in leisure time activities, decrease in criminal activity, and new roles for the patient in the prevention and treatment of addiction in others—all, again, at the individual level; (3) involvement of professional personnel at line, supervisory, and administrative levels of responsibility in planning for the treatment and rehabilitation of individual patients or groups of patients; (4) the development of new approaches in the community for stabilizing and maintaining patients with problems of drug dependence *in the community;* (5) changes in agency policy and procedures as they relate to treatment and rehabilitation planning; (6) dissemination of accumulated knowledge about problems of addiction and communitywide approaches to such problems; and (7) refinement of methods of early detection and prevention of addictive behavior.

As one defines these new objectives, staff roles require change. Of primary concern for the moment is the role of the community organizer in this new context.

Any attempt to transpose the traditional roles of the community organizer into the area of drug dependence would lead to complete frustration on the part of the practitioner. The grass roots approach makes little sense, for he would soon find that he was organizing groups of substance-using persons about whom few others care and with whom rests little political power. Attempts at coordination of welfare resources for these individuals would make even more obvious the inescapable reality that there are more gaps than there are services; the coordination of nonexistent services is hardly possible.

In a community mental health context, we can consider a different approach to the use of the community organizer's knowledge and skills, if we keep in mind some of the primary elements in the problem of substance use—community attitudes, public policy, and professional treatment goals. The community organizer's methods *can* be brought to bear on these elements, for his professional education and function is in understanding of individual and group dynamics, knowledge of community structure and resources, and an ability to develop structural forms in which a process of interrelationship can take place.

Effective implementation of change requires knowledge, understanding, and the experience of applied actions. Changes in attitudes, policies, and treatment approaches in drug dependence require the dissemination of knowledge about these problems to the levels of target persons previously noted. With these objectives and targets of intervention clearly spelled out at the community level, the new role for the community organizer is that of community *educator*. The term educator is used here in its broadest sense to describe one who can participate in a mutual process of teaching and learning in an area of substantive content. The word community is used to describe the broad range of target persons or fields at which such educational efforts can be aimed: patients, families, employers, agency personnel, and professionals.

The knowledge and training of the community organizer place him in an important focal position, as sociologists, psychiatrists, psychologists, and other behavioral scientists and practitioners seek to apply their skills to social health problems at the community level. One vital element in the role of the community organizer-educator is that of selection—the selection of the appropriate clinical and analytical materials for use with the appropriately selected target groups in order to achieve a specific goal. His strategic position as the "practitioner-at-large," knowledgeable in and drawing upon both clinical and analytic experience, permits such selectivity.

In this framework, the community organizer no longer need rely on the random involvement of large numbers of people to achieve a goal, hoping that in such a process the knowledge, content, analysis, and evaluation of the problem will ultimately come forth. He can now engage in predetermined actions aimed at specific goals and draw upon the most appropriate materials and methods for his purpose.

The community organizer's function as educator reflects his activity in serving personnel of community resource agencies in an effort to bring about more effective systems of care delivery; as his efforts affect individuals in need of these resources, he could be called a "negotiator-in-advance," for his activity is designed to bring about a situation in which the parties in a social project (in this case, prevention, treatment, and rehabilitation) can work with one another in a mutually beneficial interchange.

APPENDICES

APPENDIX A

GLOSSARY OF DEPENDENCE PRODUCING DRUGS

The drugs listed all affect the central nervous system in some way; major divisions are made by the primary characteristics of that effect. Brand names are capitalized. When the generic name is in common use, it is given without capitalization. This list is by no means complete (for example, mace, bay leaves, glue, gasoline, cleaning fluid, antihistamines, and morning glory seeds are not included). However, it does include those substances which have received most attention by legal and medical authorities.

SYSTEMIC ANALGESICS

NATURAL OPIATES
- opium
- morphine
- heroin
- codeine
- Pantopon
- Dilaudid
- Numorphan

SYNTHETIC OPIATES
- Dolophine (methadone)
- Demerol (meperidine)
- Leritine (anileridine)

NARCOTIC ANTAGONISTS
- Nalline (nalorphine)
- cyclazocine

NONNARCOTIC ANALGESICS
- aspirin
- phenacetin
- acetanilid
- Darvon

CENTRAL NERVOUS SYSTEM DEPRESSANTS

BARBITURATES
- Luminal (phenobarbital)
- Nembutal (pentobarbital)
- Seconal (secobarbital)
- Amytal (amobarbital)
- Tuinal (secobarbital and amobarbital)

NONBARBITURATE SEDATIVES
- Miltown (meprobamate)
- Equanil (meprobamate)
- Doriden
- Placidyl
- paraldehyde
- chloral hydrate

ALCOHOL

CENTRAL NERVOUS SYSTEM STIMULANTS

AMPHETAMINES
- Benzedrine (amphetamine)
- Biphetamine (amphetamine)
- Desoxyn (methamphetamine)
- Dexedrine (dextroamphetamine)
- Dexamyl (dextroamphetamine and amobarbital)

COCAINE

CAFFEINE

NICOTINE

PSYCHOTROPICS

TRANQUILIZERS
- MAJOR
  - PHENOTHIAZINES
    - Thorazine (chlorpromazine)
    - Sparine
    - Compazine
    - Stelazine
    - Mellaril
  - RESERPATES
    - Serpasil (reserpine)
    - Harmonyl
- MINOR
  - Atarax
  - Librium
  - Valium

ANTIDEPRESSANTS
- Marplan
- Nardil
- Parnate
- Tofranil
- Elavil

HALLUCINOGENS
- LSD
- psilocybin
- mescaline (peyote)
- DMT

MARIJUANA

I. SYSTEMIC ANALGESICS

This category encompasses those drugs whose outstanding characteristic is their ability to reduce physical pain. Some may have other effects as well: aspirin, for example, is useful in reducing fever, while codeine is useful in controlling cough.

The natural opiates are opium itself, two of its alkaloid components, morphine and codeine, and their derivatives. Synthetic opiates are related synthetic compounds having the same range of characteristics and effects as the natural opiates.

Nonnarcotic analgesics are those substances structurally dissimilar to the opiates, with reduced potential for physical dependence.

Narcotic antagonists are mild analgesics whose pharmacological actions include blockade and antagonism of opiate drugs. That is, these drugs reduce or eliminate the effects of opiate drugs, or when given to a person physically dependent upon an opiate, they precipitate an immediate withdrawal syndrome which varies in severity with the degree of dependence.

NATURAL OPIATES

opium
morphine
heroin
codeine
Pantopon
Dilaudid
Numorphan

REGULATION. Federally controlled by the Harrison Act as amended and by individual state laws; all except heroin may be prescribed in the treatment of illness by a doctor having a narcotic licence (permission to use heroin for research must be obtained from the Treasury Department). Opiates are obtainable for individual medicinal use only on prescription (except some exempt preparations like cough syrup). Unauthorized possession, sale, manufacture, etc., are punishable federally and under state laws.

FORM. Generally in liquid form for parenteral administration in medical practice; codeine in many forms, including liquid and tablet; Dilaudid and Numorphan also in tablet form. Opium may be smoked. Heroin and morphine on the illegal market generally in powder form for inhalation or to be dissolved ("cooked up") for injection.

EFFECT. Tolerance is rapid and can be established within the therapeutic dose range. Severity of withdrawal syndrome parallels dosage. Potent analgesia with no physiological damage within therapeutic range. Order of effects: first, respiratory center is depressed, then higher centers depressed, producing analgesia and sleep; lethargy, coma, or fatal respiratory depression result from overdose. Overdose treated by administration of narcotic antagonist. Immediate euphoric effect upon injection varies with drug and with tolerance; most pronounced with heroin. Therapeutic dose does not impair ability to think nor cause motor incoordination. A notable relief from anxiety is commonly reported. Medical withdrawal (detoxification) is generally accomplished by administrtaion of progressively decreasing dosages of methadone.

SYNTHETIC OPIATES

Dolophine (methadone)
Demerol (meperidine)
Leritine (anileridine)

REGULATION. Legal control and penalties as outlined under "natural opiates" above.

FORM. In liquid form for parenteral administration or tablet form for oral dosage (the liquid methadone may be used either parenterally or orally). When self-administered, the tablet forms are often dissolved in water for injection.

EFFECT. Characteristic effects are outlined under "natural opiates" above. Ability to produce euphoria seems considerably reduced in the synthetic opiates; also reduced is the incidence of side effects, such as vomiting, which sometimes occur with morphine dosage. Cross-tolerance is exhibited among the natural and synthetic opiates.

NARCOTIC ANTAGONISTS

Nalline (nalorphine)
cyclazocine

REGULATION. Prescription necessary for purchase, but not subject to narcotic restrictions.

FORM. Both Nalline and cyclazocine available in liquid form for parenteral administration. In present usage, cyclazocine is generally given in liquid form orally; a depot form is being developed.

EFFECT. Nalline is commonly used in the treatment of narcotic overdose; injection neutralizes the effect of the opiate drug. It is also used to detect addiction to narcotics (except codeine and Demerol), as administration of Nalline to an individual physically dependent upon an opiate rapidly precipitates a withdrawal syndrome. Tolerance to Nalline develops upon chronic administration, and the withdrawal syndrome resembles that of the opiates. Cross-tolerance is shown between Nalline and cyclazocine. Use of cyclazocine in the treatment of narcotic abusers has recently been undertaken. It is given in progressively increasing doses to build up tolerance; when an opiate drug is subsequently taken, no narcotic effect results. Analgesia is mild; no physiological damage has been reported. Subjective effects are minimal unless dose is increased rapidly; sensory distortions then sometimes occur. Abstinence symptoms occur on the 4th day of withdrawal when tolerance has developed to parenteral doses, and after 36 hours when dosage has been oral. The withdrawal syndrome is similar to, but less severe than, that of the opiate drugs.

NONNARCOTIC ANALGESICS

aspirin
phenacetin
acetanilid
Darvon

REGULATION. These drugs are not subject to narcotic regulation; some, however, may be obtained only on prescription (that is, distribution is regulated). There is no specific law against possession; aspirin, of course, may be obtained and possessed by anyone.

FORM. In tablet or capsule form for oral administration.

EFFECT. Tolerance is slow to develop; withdrawal syndrome has not been described. Analgesia (less potent than that from the opiates) with no physiological damage in the therapeutic range. Central Nervous System (CNS) depression from large doses. No appreciable euphoria; some psychotropic effect from very large doses, particularly of Darvon.

II. CENTRAL NERVOUS SYSTEM DEPRESSANTS

These drugs have as their outstanding characteristic a sedative or, in larger quantities, an hypnotic action. That is, they quiet or put to sleep through depression of the central nervous system. They may, in addition, show analgesic qualities at high dosage, but the depression of central nervous system function predominates. Their ability to change mood is marked, but this is an indirect function of the "relaxing" quality, in removing inhibitions and releasing tension, rather than a result of the kind of direct action shown by, for example, the tranquilizers.

BARBITURATES

Luminal (phenobarbital)
Nembutal (pentobarbital)
Seconal (secobarbital)
Amytal (amobarbital)
Tuinal (secobarbital and amobarbital)

REGULATION. Federally controlled by the Drug Abuse Control Amendments of 1965 which regulates manufacture and distribution (possession per se is not regulated) and by state laws which, as in New York, may also regulate possession. May be obtained legally for individual use only on prescription.

FORM. Generally in capsule form for oral administration; sometimes given intravenously to produce narco-synthesis in psychiatric practice or as an adjunct to anesthesia.

EFFECT. Widely prescribed as "sleeping pills." Little tolerance develops to the minimum lethal dose. Strong psychic dependence and strong physical dependence at the abuse level, though not usually "addicting" in the therapeutic dose range. The general depressant effect of the barbiturates may be reversed, in elderly persons or in those taking high dosages, to a stimulant effect. Cross-tolerance is shown among the group. Phenobarbital is the slowest acting, but its effect is more prolonged. Controlled therapeutic dosage is unlikely to be accompanied by serious side actions or toxic effects. However, organic damage and toxic psychoses occur at abuse levels; sensory distortion and motor incoordination are common. Overdose may be treated by careful administration of an analeptic, such as Metrazol. The barbiturates and alcohol potentiate each other's actions and are particularly dangerous in combination, which can result in fatal respiratory depression. The two tend, also, to support each other in withdrawal. The barbiturate withdrawal syndrome is generally more dangerous to life than that of the opiates. Improvement is shown during the first 12 to 16 hours, but then tremor, hyperactivity, cramps, nausea, elevated blood pressure and temperature, and signs of cerebellar dysfunction appear. Grand mal convulsions may occur, usually at about the 30th hour. Because of the seriousness of the withdrawal syndrome, which may be brought on even by a moderate reduction of the accustomed dose, medical withdrawal is accomplished by very gradual reduction of dose, extending over a period of at least 3 to 4 weeks, after an initial stabilization at a level sufficient to maintain mild intoxication.

NONBARBITURATE SEDATIVES

Miltown (meprobamate)
Equanil (meprobamate)
Doriden
Placidyl
paraldehyde
chloral hydrate

REGULATION. In general the manufacture and distribution of these drugs are controlled by the Drug Abuse Control Amendments of 1965 and the comparable state laws as "depressant" drugs requiring prescription.

FORM. Meprobamate and Doriden available in tablet form; Placidyl as a liquid in a gelatin capsule; and paraldehyde and chloral hydrate as unpleasant liquids.

EFFECT. Meprobamate (recently reclassified from tranquilizer to sedative), Doriden, and Placidyl are generally used as sedatives and muscle relaxants; paraldehyde is widely used to combat delirium tremens associated with alcohol withdrawal; and chloral hydrate is primarily used to induce sleep. Tolerance and withdrawal characteristics are similar to those described above for the barbiturates. Overdose treatment is nonspecific and supportive. Not surprisingly, most paraldehyde addicts first encountered the drug while being treated for alcoholism.

ALCOHOL

alcohol

REGULATION. Production (unauthorized "bootleg" production is prohibited) and distribution is subject to Federal and state taxing regulations; limits established locally circumscribe age of individuals to whom alcohol may be sold or served.

FORM. The U.S.P. preparation contains approximately 95-percent ethyl alcohol by volume. The almost innumerable popular forms include: beer, wine, whiskey, liquers, cough syrup, Sterno, and hair tonic.

EFFECT. Medically, alcohol may be used as an analgesic, a vasodilator, and of course as an hypnotic or "tranquilizing" agent. Of far greater consequence, however, is its social use. It is not included here with the mood-changing drugs, because its ability to change one's outlook comes about through central nervous system depression, which relaxes controls and increases emotional receptiveness. Its only stimulant effect is on the production of gastric secretion. Cross-tolerance is shown with the barbiturates (and for ether and chloroform). All degrees of psychic dependence are shown. Physical dependence is slow to develop. Tolerance also develops slowly, and is reduced in later stages of addiction. The behavioral correlates of alcohol use are too well known to require narration. Acute toxicity may result in fatal respiratory depression. Overdose may be treated by arousing the victim, if possible, or administering a cerebrally acting analeptic such as caffeine. Symptoms of chronic toxicity include psychoses and organ damage, particularly to the liver and brain. Administration of sedatives and tranquilizers in the treatment of chronic alcohol dependence should be undertaken with caution, since the drugs are liable to potentiate one another. Abrupt withdrawal in the face of physical dependence may induce convulsions or delirium tremens.

III. CENTRAL NERVOUS SYSTEM STIMULANTS

These drugs have as their outstanding characteristic an excitory or psychomotor stimulant effect. They have no systemic analgesic properties (although cocaine is a topical anesthetic). Like the barbiturates, these drugs show marked ability to alter mood and/or behavior, but again this is due to general stimulation of the central nervous system rather than to specific action on control centers in the brain.

AMPHETAMINES

Benzedrine (amphetamine)
Biphetamine (amphetamine)
Desoxyn (methamphetamine)
Dexedrine (dextroamphetamine)
Dexamyl (dextroamphetamine and amobarbital)

REGULATION. As stimulant drugs, the amphetamines are Federally regulated by the Drug Abuse Control Amendments of 1965 and comparable state laws. Generally they may be obtained on prescription, but small quantities are also used in nasal inhalers, diet pills, and some "keep-awake" preparations.

FORM. Commonly in tablet or capsule form; a sustained-release form is popular for control of obesity. An injectable liquid form is also available, and is often the abuse form.

EFFECT. Widely used as part of a dieting regimen, or to increase alertness and wakefulness. Euphoric effect is not uncommon. Tolerance is slow to develop. Psychic dependence, which can start at usual dose levels, occurs with little physical dependence and no regular physical withdrawal syndrome, although psychotic behavior may be manifested by the abuser both when taking large doses and when withdrawal is undertaken. Motor incoordination and cerebellar dysfunction from large dosage or chronic use. Large dosage may result in hyperirritability, apprehension, severe headache, and striking blood pressure rise which can result in cerebral hemmorrhage. Treatment is supportive and sedative. No withdrawal technique is particularly recommended. Usually the major tranquilizers are given to control psychotic manifestations.

COCAINE

cocaine

REGULATION. Although this is inconsistent with its physiological effect (it is not a systemic analgesic with "narcotic" properties), cocaine is legally classed as a narcotic and is Federally regulated under the Harrison Act as amended and the state narcotic laws. It may be used in medical practice, and prescribed, but such prescription is subjection to the same kind of scrutiny by the Federal Bureau of Narcotics as is the prescription of opiates.

FORM. Used medically in liquid form as a topical anesthetic (for the eye); black market form is powder for inhalation or liquid form for injection.

EFFECT. When abused, very strong psychic dependence occurs. No physical tolerance or withdrawal symptoms have been reported. When inhaled, irritation and eventual damage to the mucous membranes of the nose results. Intravenous administration produces a short-lived orgiastic experience. Repeated use may cause hallucinations and delusions. The unpleasant toxic effects can be reduced by taking cocaine in conjunction with a physiologic antidote such as heroin. Treatment of cocaine convulsions resulting from overdose includes administration of a barbiturate.

CAFFEINE AND NICOTINE

caffeine
nicotine

REGULATION. Beverage caffeine is not regulated at all, nor is the drug itself, when used medically. Nicotine as such is not regulated, but the sales of tobacco products of which it is a component are subject to Federal and state taxing regulations; the age of the buyer is often restricted.

FORM. Caffeine is often used medically as one component in analgesic preparations. Nicotine, being highly poisonous, is not used medically (it does make an effective insecticide, however); it is found in varying amounts in cigars, cigarettes, pipe and chewing tobaccos. Caffeine is an ingredient of coffee and some soft drinks (a closely related compound, theophylline, is the stimulant ingredient in tea).

EFFECT. Some tolerance to the physical effects of caffeine develops, but unaccustomed large amounts cause sleeplessness, irregular heartbeat, or gastric hyperacidity. Central nervous system stimulation results in improved mentation and sensory perception. Dependence on caffeine (coffee) to "get going" is extremely widespread. Descriptions of the withdrawal syndrome are largely journalistic, emphasizing such factors as general discomfort, tension, and "nervousness."

There is strong evidence that nicotine as the principal alkaloid in tobacco is, in fact, the chemical substance related to the development of the smoking "habit," for when minute amounts of nicotine are given in some other form to abstinent smokers, craving is sometimes reduced. Small quantities of nicotine stimulate and large quantities block ganglionic transmission. Since this is a glossary of dependence-producing *substances,* nicotine has been singled out, though it is highly probable that it is the whole *activity* of smoking upon which dependence is based, just as the activities surrounding drug use may be an important part of the process of narcotic dependence. That is, the ritual of smoking with its element of sociability, oral gratification, and reinforcement from the effects of the chemical substance, may be the object to which dependence is attached (likewise, a "needle habit" has been described in some narcotic addicts). Abstinence is often accompanied by the jitters, weight gain and other unpleasant, but hardly life-threatening symptoms; it is postulated that the dependence develops as primary pleasure becomes subordinated to use in warding off pain (anxiety) associated with abstinence. The deleterious physiological effects, including death, associated with smoking have been well documented; this has had no appreciable influence on the incidence of the behavior.

IV. PSYCHOTROPICS

These drugs characteristically affect mood and behavior without general stimulation or depression of the central nervous system. Analgesic or anesthetic properties are generally absent. In other words, they alter the way one feels, with only slight change in the physiological functions.

TRANQUILIZERS

Thorazine (chlorpromazine)
Sparine
Compazine
Stelazine
Mellaril
Serpasil (reserpine)
Harmonyl
Atarax
Librium
Valium

REGULATION. Federally controlled by the Drug Abuse Control Amendments of 1965 which regulates manufacture and distribution (possession per se is not regulated); and by state laws which, as in New York, may also regulate possession. May be obtained only on prescription.

FORM. In tablet or capsule form; or as a liquid for parenteral administration (no black market traffic in this form has been noted).

EFFECT. The tranquilizers are divided into two groups, major and minor. The major tranquilizers are again divided as: phenothiazines (Thorazine, Sparine, Compazine, Stelazine, Mellaril, etc.) and resarpates (Serpasil, Harmonyl, etc.). The minor tranquilizers include Atarax, Librium, Valium, etc. The major tranquilizers show antipsychotic activity; the minor tranquilizers do not, but are useful in dealing with neurotic symptoms, particularly anxiety. Tranquilizers do not necessarily show a sedative or depressant or hypnotic action themselves, but they do potentiate the effects of the opiates, barbiturates, and alcohol. Interruption of thinking processes or motor incoordination are uncommon. Toxic side effects are not usually serious, although jaundice and hepatitis may appear. Withdrawal phenomena associated with major tranquilizers are predominantly psychic.

ANTIDEPRESSANTS

Marplan
Nardil
Parnate
Tofranil
Elavil

REGULATION. These drugs, available only on prescription, will also be regulated under the Drug Abuse Control Amendments of 1965 and comparable state laws.

FORM. The monoamine oxidase inhibitors Marplan, Nardil, and Parnate, are available in tablet form. Tofranil and Elavil are either tablets or liquid for intramuscular injection.

EFFECT. These drugs are specifically effective in bringing about remission of symptoms of severe depression. They cause considerable psychic stimulation or euphoria, generally without sensory or perceptual distortion. As is the case with tranquilizers, some tolerance develops, and stoppage of accustomed high dosage results in withdrawal symptoms with psychiatric components. Physiological damage (particularly to the liver) and other toxic side effects can occur. The antidepressants can potentiate the effects of alcohol and sedatives; conjunctive use is contraindicated.

HALLUCINOGENS

LSD (lysergic acid diethylamide)
psilocybin
mescaline (peyote)
DMT

REGULATION. The hallucinogenic drugs also come under the Drug Abuse Control Amendments of 1965 and comparable state laws. Considerable public chaos about LSD use has resulted in an at least temporary halt to its use in medical and psychiatric research projects in this country. Mescaline has long been used in religious ceremonies by North American Indian tribes; the legal implications of this are not yet altogether clear.

FORM. LSD and DMT are synthetic compounds generally available on the black market as a tablet or sugar cube in which a few drops of the liquid chemical have been absorbed. Psilocybin is a naturally occurring component of a Mexican mushroom. Mescaline is a naturally occurring alkaloid in the flowering head (button) of the peyote cactus. The drugs are usually taken orally; parenteral administration is also feasible.

EFFECT. Cross tolerance is exhibited among the hallucinogens. Psychic dependence develops strongly. A very high degree of tolerance develops upon repeated administration. No physical dependence or withdrawal syndrome has been reported. Use of the hallucinogens, particularly LSD, may allow clinical production of behavior resembling that associated with psychosis; whether this effect occurs in self-administration seems to be largely a function of the environment and the personality of the subject. LSD has been successfully used as an adjunct to the psychiatric treatment of alcoholism. The usual subjective effects of the hallucinogens include a whole concatenation of paranormal experiences which are frequently characterized as "mystic" or in some way religious. Throughout the experience the subject is aware that his perception has in fact been altered and the experience is an abnormal one. Synesthesia is marked. Visual hallucinations and illusions are pronounced with shapes and colors of objects particularly striking. Depersonalization, dissociation, and body image distortion occur. However, the experience neither feels like nor, to an observer, looks like, delirium or intoxication. The retrospective impressiveness of the experience is generally noted. Physiological damage from chronic use has not been reported; toxic psychoses have been, however. Overdose, or unexpected unpleasant effects, can be counteracted by adrenergic or ganglionic blocking agents or the phenothiazines, such as Thorazine, together with psychic support.

MARIJUANA

marijuana

REGULATION. Marijuana is Federally regulated under the 1937 Marijuana Tax Act (modeled after the Harrison Act) as amended, and comparable state laws. Production, distribution, sale, and possession are all subject to penalty.

FORM. Marijuana, consisting of the dried leaves, stems and seed pods of Indian hemp, is most often smoked, sometimes as a mixture with tobacco. A tea may also be brewed from the plant.

EFFECT. Moderate psychic dependence often develops, as is the case with tobacco. There is no physical dependence, no withdrawal symptoms, no increase in tolerance, and little tendency to increase the amount used. The effects are experienced as exhiliration, relaxation, and sensory and temporal distortion, generally of a pleasantly intoxicating nature. Unlike alcohol, there is no hangover, nor any physiological damage unless massive quantities are used.

MATERIALS CONSULTED IN THE PREPARATION OF THIS GLOSSARY INCLUDE, IN ADDITION TO ITEMS LISTED IN THE BIBLIOGRAPHY, THE FOLLOWING:

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APPENDIX B
SCREENING INSTRUMENT

Division of Community
Mental Health 3D 2-67

SCREENING INTERVIEW SCHEDULE

New York Medical College
Department of Psychiatry

CONFIDENTIAL

PART I

_ _ _ _ _ (A1 - 5)
P N N N N

COMPLETED __ __ __
Mo. Day Year

REFERRED

BY .... # ___ (A6 -14)

INTERVAL DAYS ___ (A15-23)

1. PRE-INTERVIEW

A.TIME	B.ACTION	C.BY
....	....	....
....	....	....
....	....	....
....	....	....

2. OPENING THE INTERVIEW

A.VERIFY NAME & ADDRESS

B.INTRODUCE PROGRAM

C.DATE NOW ....

D.HOUR NOW .... a.m. p.m.

E.READ TO R:

This interview usually takes about one hour and a quarter. Everything you say is strictly confidential. The information is used for research and for planning treatment. Nothing you tell us will be given to anyone else without your permission. CONTINUE OVER.

3. POST-INTERVIEW--SAMPLING ITEMS

A.KEY ITEMS	B.SUM A	C.% COMPLETE	D.WHY C
	(A24)	(A25)	(A26)
[1] Q.4, I.D.	0	0 No int.	0 Not sought
___ NO ___ YES	1	1 to 19%	1 Not reached
	2	2 20-29	2 Not willing
[2] Q.6, A.S.R.	3	3 30-39	3 Language problem
___ NO ___ YES	4	4 40-49	4 Comprehension problem
	5	5 50-59	5 Incapacitated
[4] Q.14, U.I.	6	6 60-69	6 Deceased
___ NO ___ YES	7	7 70-79	7 Other reason
		8 80-89	8 NA
		9 90 +	9 DNA (90+% in C)
		Also Known As	+ Transferred From (mp)
		_ _ _ _ _ _	- Transferred To (mp)

4. INITIAL DESCRIPTION

First, I would like to ask you a few questions about yourself.

A. How tall are you without shoes?

.....ft .....in

B. How much do you weigh in ordinary clothes?

.....lbs

C. What was your date of birth?

....

(A27) A.HEIGHT	(A28) B.WEIGHT	(A29) C.AGE
1 Under 5'	1 Under 100	1 Under 15
2 5'0"-5'1"	2 100-114	2 15-19
3 5'2"-5'3"	3 115-129	3 20-24
4 5'4"-5'5"	4 130-144	4 25-29
5 5'6"-5'7"	5 145-159	5 30-34
6 5'8"-5'9"	6 160-174	6 35-39
7 5'10"-5'11"	7 175-189	7 40-49
8 6'0"-6'1"	8 190-204	8 50-59
9 6'2" & over	9 205 & over	9 60 & over
0 NA	0 NA	0 NA

D. & E. DO BY INSPECTION

(A30) D.SEX	(A31) E.COLOR	
1 Male	1 White	3 Yellow
2 Female	2 B.-Br.	4 Other
		0 NA

F. Are you now single, married, widowed, divorced, separated, or what?
IF R IS MALE OR SINGLE, SKIP G

(A32) F.MARITAL STATUS		
1 Single	3 Widowed	5 Separated
2 Married	4 Divorced	6 Other:
		0 NA

G. What was your maiden name? ....

H. What was the last grade you completed in school?

........grade

I. When was that?

........year

J. How far did your father go in school?

....

H.R's (A33)	J.F's (A34)	EDUCATION
1	1	None
2	2	Some grade school
3	3	Grade school graduate
4	4	Some high school
5	5	High school graduate
6	6	Some college
7	7	College graduate
8	8	Post-graduate
9	9	DK
0	0	NA

K. & L: IF PROTESTANT--DENOMINATION? IF JEW--ORTHODOX, CONSERVATIVE, REFORM?

K. In what religion did you grow up?

....

L. What is your religion now?

....

K.WAS (A35)	L.NOW (A36)	RELIGION
1	1	Protestant
2	2	Catholic
3	3	Jew
4	4	None
5	5	Other Christian
6	6	Other non-Christian
7	7	DK
0	0	NA

5. INITIAL NARRATIVES

A. What would you say are your serious problems now? (anything else?)

B. Who else is involved in these problems? (how?)

C. What have you done so far to get help?

D. How did you happen to come to us?

E. What do you think should be done to help you? (by us? by anyone else?)

6. AREA SELF-RATINGS

For each of the following things, please tell me whether you would describe it now as excellent, good, fair, poor, or very poor.

	EXCEL-LENT	GOOD	FAIR	POOR	VERY POOR	NA	
A. In general, your ability to get along in life.	5	4	3	2	1	0	(A37)
B. Your enjoyment of your spare time.	5	4	3	2	1	0	(A38)
C. Your relations with friends and acquaintances.	5	4	3	2	1	0	(A39)
D. Your relations with family members.	5	4	3	2	1	0	(A40)
E. The place where you live, as a home for you.	5	4	3	2	1	0	(A41)
F. Your work life (on the job, in the home, or at school).	5	4	3	2	1	0	(A42)
G. Your ability to handle the habits that can harm you.	5	4	3	2	1	0	(A43)
H. Your ability to stay out of trouble, especially with the law.	5	4	3	2	1	0	(A44)
I. Your ability to get service from agencies and professionals.	5	4	3	2	1	0	(A45)
J. Your health in general.	5	4	3	2	1	0	(A46)

7. WELL-BEING SELF-RATINGS

A. Your physical health.	5	4	3	2	1	0	(A47)
B. Your mental health.	5	4	3	2	1	0	(A48)
C. Your sex life.	5	4	3	2	1	0	(A49)
D. Your happiness.	5	4	3	2	1	0	(A50)
E. Your hope for your future.	5	4	3	2	1	0	(A51)

8. WELL-BEING NARRATIVES

A. In what ways could your physical health be better now? (any handicaps? any illnesses? anything that bothers you?)

B. In what ways could your mental health be better now?

C. In what ways could your sex life be better now?

D. In what ways could you be happier or more hopeful?

E. What do you want out of life?

9. AGENCY CONTACTS, AMBULATORY

Have you ever gone to any of the following--now, or only in the past, or never?

	NOW	PAST	NEVER	NA	
A. A lawyer	1*	2	3	0	(A52)
B. A probation officer	1*	2	3	0	(A53)
C. A parole officer	1*	2	3	0	(A54)
D. A clergyman	1*	2	3	0	(A55)
E. A dentist	1*	2	3	0	(A56)
F. A private doctor for psychiatric help	1*	2*	3	0	(A57)
G. A private doctor for any other reason	1*	2	3	0	(A58)
H. A clinic for psychiatric help	1*	2*	3	0	(A59)
I. A clinic for any other reason	1*	2	3	0	(A60)
J. A social work agency	1*	2*	3	0	(A61)
K. The Department of Welfare	1*	2*	3	0	(A62)
L. An employment agency	1*	2	3	0	(A63)
M. A special program like A.A. or Synanon	1*	2*	3	0	(A64)

10. AGENCY CONTACTS, CUSTODIAL

Altogether in your life, how many times have you been--

A. A patient in a hospital for mental observation or treatment.

B. A patient in a hospital for any other reason

C. In jail or reform school.

D. Arrested.

M.HOSP A.(A65)	O.HOSP B.(A66)	JAIL C.(A67)	ARREST D.(A68)	TIMES
0	0	0	0	Never
1	1	1	1	One
2	2	2	2	Two
3	3	3	3	Three
4	4	4	4	Four
5	5	5	5	Five
6	6	6	6	Six
7	7	7	7	Seven
8	8	8	8	Eight +
9	9	9	9	NA

11. AGENCIES CHART: COVER ANY STARRED (*) RESPONSES IN Q.9 AND ALL RESPONSES IN Q.10.

A.WHAT AND WHERE About the (first) time you were ____, where was that? (organization and city?)	B.WHEN When was that (to when?)	C.PERSON Whom did you see (who had your case?)	D.PROBLEM AND OUTCOME What was the trouble (the charge), and how did it turn out?
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....

N.B. FOR PRESENT WELFARE CLIENTS, ENTER UNIT AND WELFARE NUMBER IN BOX

FOR EVERYONE: SOCIAL SECURITY NUMBER ___-__-____

E. FINAL PROBE: Have we left out any time that you went for help for any serious problem?

PART II

12. DRUG LISTING

Next I will read a list of drugs of various kinds. Please say Yes for each one that you have ever used, at any time in your life. What about Opiates such as heroin...? FOR EACH YES, CIRCLE CODE NUMBER.

A. SYSTEMIC ANALGESICS

Opiates
06 heroin
07 bombitas (H+Desoxyn)
08 speedballs (H+cocaine)
09 opium
10 morphine
11 codeine
12 Pantopon
13 Dilaudid
14 Dolophine
14 methadone
15 Demerol
15 meperidine
16 Leritine
16 anileridine
17 Numorphan
18 ....

Narcotic Antagonists
20 Nalline
20 nalorphine
21 cyclazocine
22 ....

Other Analgesics
24 aspirin
24 phenacetin
24 acetanilid
25 Darvon
26 ....

B. CNS DEPRESSANTS

Barbiturates
28 Luminal
28 phenobarbital
29 Nembutal
29 pentobarbital
29 yellow jackets
30 Seconal
30 secobarbital
30 red devils
31 Amytal
31 amobarbital
32 Tuinal
33 ....

Hypnotics
34 Placidyl
35 Miltown
35 Equanil
35 meprobamate
36 paraldehyde
37 chloral hydrate
38 Doriden
38 cibas
39 Compoz
40 ....

NOTE:

BRAND NAMES ARE CAPITALIZED.
GENERIC NAMES ARE LOWER CASE.
DRUG CLASSES ARE UNDERLINED.

C. CNS STIMULANTS

Amphetamines
41 Benzedrine
42 Biphetamine
43 Dexedrine
44 Desoxyn
44 Methedrine
45 Dexamyl
46 ....

Other Stimulants
48 No-Doz
48 caffeine, as a drug
49 cocaine
50 ....

USE COL.40 FOR ANTIHISTAMINES

D. PSYCHO-TROPICS

Tranquilizers
51 Thorazine
51 chlorpromazine
52 Compazine
53 Stelazine
54 Mellaril
55 Serpasil
55 reserpine
56 Harmonyl
57 Librium
58 Valium
59 Atarax
60 ....

Anti-Depressants
61 Marplan
61 Nardil
61 Parnate
62 Tofranil
63 Elavil
64 ....

Psychedelics
65 LSD
66 psilocybin
67 mescaline
67 peyote
68 DMT
68 DET
69 marijuana
70 ....

USE TYPOLOGY

IMP.	Now	6mo	Ever
Most	1	2	3
Also	4	5	6
Not	7	8	9

CODING

Number at left of substance tells column for entering use type (1-9, DK=0, Not used=blank). Source of info is Q.8-9. In columns 76-77 enter code of R's major substance; DK=99, NA=00

Others
71 Alcohol drinks
72 Alcohol substitute
73 Tobacco
74 Etherials
75 Any other
76-77 Major subs

1		41	
2		42	
3		43	
4		44	
5		45	
6		46	
7		47	
8		48	
9		49	
10		50	
11		51	
12		52	
13		53	
14		54	
15		55	
16		56	
17		57	
18		58	
19		59	
20		60	
21		61	
22		62	
23		63	
24		64	
25		65	
26		66	
27		67	
28		68	
29		69	
30		70	
31		71	
32		72	
33		73	
34		74	
35		75	
36		76	
37		77	
38		78	
39		79	
40		80	

13. OTHER SUBSTANCES

Next are a few questions about other things besides drugs that people use.

A. Have you ever had any alcoholic beverage--beer, wine, or liquor? IF YES: Which?	(C 6) BEVERAGES (SUM) 1 Beer 9 None 2 Wine 0 NA 4 Liquor
B. Have you ever had preparations like cough medicine or vanilla extract as substitutes for liquor? Have you ever had products like rubbing alcohol or hair tonic as substitutes for liquor? IF YES: Which?	(C 7) SUBSTITUTES (SUM) 1 Preparations 2 Products 9 None 0 NA
C. Have you ever smoked any tobacco products--cigarettes, cigars, or pipe? IF YES: Which?	(C 8) TOBACCO (SUM) 1 Cigarettes 9 None 2 Cigar 0 NA 4 Pipe
D. Have you ever sniffed things like glue or gasoline? IF YES: Which?	(C 9) ETHERIALS (SUM) 1 Gasoline 9 None 2 Glue 0 NA 4 Other:

14. USE ITEMS

The next questions refer to any drugs or other things like alcohol or tobacco that you have ever used.

A. Which ones do you use now?

B. Which others have you used in the past six months?

C. Which ones would you say have played an important part in your life?

IF NONE IN C, SKIP D

D. Which single one would you say has played the most important part in your life?

E. THE REST OF PART II VARIES BY PROGRAM. CIRCLE AT RIGHT THE ONE TERM YOU WILL USE IN PLACE OF EACH ___ BLANK BELOW.

(C10) PROGRAM & TERM
1 "A" = Drinking
2 "B" = Taking drugs
3 "C" = Smoking

15. SUBSTANCE CIRCUMSTANCES

Next are some ways in which people may do their ___ . For each one, please tell me if it has been true for you--would you say Recently, meaning in the past six months, or only Before then, or Never?

	REC.	BEF.	NEV.	NA	
A. ___ before having any breakfast.	3	2	1	0	(C11)
B. ___ mainly (or only) when you are alone.	3	2	1	0	(C12)
C. ___ mainly (or only) on weekends.	3	2	1	0	(C13)
D. ___ mainly (or only) at home.	3	2	1	0	(C14)
E. Being afraid of getting caught without a supply.	3	2	1	0	(C15)
F. Trying to cover up how much you use.	3	2	1	0	(C16)
ASK G-J FOR "A" PROGRAM ONLY					
G. Drinking during the daytime	3	2	1	0	(C17)
H. Drinking all weekend long	3	2	1	0	(C18)
I. Going on benders during the week	3	2	1	0	(C19)
J. Drinking with people you wouldn't care to know otherwise.	3	2	1	0	(C20)

16. SUBSTANCE REASONS

Here are some possible reasons for ___ . Again, please tell me if each has been true for you Recently, or only Before then, or Never.

A. To feel pleasant or high	3	2	1	0	(C21)
B. To go along with a group	3	2	1	0	(C22)
C. To go along with a particular person	3	2	1	0	(C23)
D. To loosen up in a social situation	3	2	1	0	(C24)
E. To help to get to sleep	3	2	1	0	(C25)
F. To help to go without eating	3	2	1	0	(C26)
G. Because of outside pressures	3	2	1	0	(C27)
H. Because of physical pain or illness	3	2	1	0	(C28)
I. Because of painful feelings or thoughts	3	2	1	0	(C29)
J. Because of tension or nervousness	3	2	1	0	(C30)
K. Because of feeling down or disappointed	3	2	1	0	(C31)
L. Because of building up a craving	3	2	1	0	(C32)
M. Because it's an everyday necessity	3	2	1	0	(C33)

17. SUBSTANCE EFFECTS

Next are some things that may happen as a result of ___ . For each one, please tell me if it has happened to you; would you say Recently, meaning in the last six months, or only Before then, or Never?

	REC.	BEF.	NEV.	NA	
A. Complaints from people you know about your ___ .	3	2	1	0	(C34)
B. Friendships dropping off because of your ___ .	3	2	1	0	(C35)
C. Damage to family relations due to your ___ .	3	2	1	0	(C36)
D. Leaving jobs because of your ___ .	3	2	1	0	(C37)
E. Trouble with the law due to your ___ .	3	2	1	0	(C38)
F. More tolerance, when it takes more to have an effect on you.	3	2	1	0	(C39)
G. Loss of control, where you can't seem to stop yourself from overdoing it.	3	2	1	0	(C40)
H. Less tolerance, when it takes less than it used to to have an effect.	3	2	1	0	(C41)
I. Tremors, or having the shakes as a result of your ___ .	3	2	1	0	(C42)
J. Inhibition, when you just can't do the simplest thing without it.	3	2	1	0	(C43)
K. Loss of time sense, when you can't keep track of time so well	3	2	1	0	(C44)
L. Poor concentration or forgetfulness.	3	2	1	0	(C45)
ASK M-P FOR "A" PROGRAM ONLY					
M. Blackouts, or blanks in your memory about times you had been drinking.	3	2	1	0	(C46)
N. Hallucinosis, where you are calm but see or hear things that are not real.	3	2	1	0	(C47)
O. Delirium, where you are agitated and see or hear things that are not real.	3	2	1	0	(C48)
P. Convulsions, or throwing a fit.	3	2	1	0	(C49)

18. SUBSTANCE HISTORY CHART: COVER THE INFORMATION OF Q. 12-17 BY TIME.

Please tell me about the period in your life when you first started ___ . ASK A-E. What about the period after that in your ___ . ASK A-E, ETC. AFTER LAST PERIOD, PROBE ON INFORMATION NOT YET CHARTED: What about (substance, circumstances, reason, effect)? *IN B, T-F-A = TYPE, FREQUENCY, AMOUNT.

A.PERIOD	B.SUBS. T-F-A*	C.CIRCUMSTANCES	D.REASONS	E.EFFECTS
When did that start? When did that end?	What were you using then? How often? How much? (How?)	When did you usually ___ ? Where? With whom?	What were your reasons for ___ ?	How did it affect you? (Affect your health? Affect your life?
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....

19. SUBSTANCE NARRATIVES

A. How did you get started ___ ? What is the story?

B. How does your ___ make you feel?

C. How does it make you act?

D. How does your ___ help you?

E. How does your ___ harm you?

F. PROBE D & E BY AREA, AS NEEDED:
(1) HEALTH (2) AGENCY USE (3) USE OF OTHER SUBSTANCES (4) OFFENSES
(5) WORK (6) RESIDENCE (7) FAMILY (8) FRIENDS (9) FREE TIME

20. SUBSTANCE ATTITUDES

Next are some statements about ___ . For each one, please say Agree if it is mainly true for you, or Disagree if it is mainly not true for you.

	AGREE	DISAGREE	DK	NA		
A. I have a craving (desire) for it that never really goes away.	3	2	1	0	(C50)	C+
B. I can usually stop ___ without getting physically sick.	3	2	1	0	(C51)	D-
C. I spend little or no time with people who have the habit.	3	2	1	0	(C52)	S-
D. The only reason I need for ___ is that I enjoy it.	3	2	1	0	(C53)	P+
E. The best thing for me would be if I could learn how to live with it.	3	2	1	0	(C54)	R-
F. There are times when my body needs it to function right.	3	2	1	0	(C55)	D+
G. There are many days when I don't think about it at all.	3	2	1	0	(C56)	C-
H. There is no pleasure in ___ for me.	3	2	1	0	(C57)	P-
I. Many of the conversations I get into are about ___ .	3	2	1	0	(C58)	S+
J. I would like to get it out of my life once and for all.	3	2	1	0	(C59)	R+

21. SELF-DESIGNATIONS

A. Have you ever considered yourself--
"A": an alcoholic "B": an addict
"C": a tobacco addict

(C60) HOOKED EVER
1 Yes 3 DK
2 No 0 NA

B. What are you now--
"A": an alcoholic, a heavy drinker, a moderate drinker, a light drinker, or what?
"B": an addict, a regular user, an occasional user, a rare user, or what?
"C": a tobacco addict, a heavy smoker, a moderate smoker, a light smoker, or what?

(C61) SUBSTANCE USE NOW
1 Alcoholic, addict
2 Heavy or regular
3 Moderate or occasional
4 Rare or light
5 Abstinent
6 DK
0 NA

22. SUBSTANCE LOGISTICS

A. How much money has your ___ usually cost for one week?

B. What does that money usually buy? (How much?)

C. How have you supported your habit? (Now?)

23. KICKING

How many times have you quit or kicked--

A. Altogether in your life? ....

B. With medical help? ....

C. In jail? ....

D. "B": In the street? ....

E. "B": At home? ....

A. TOTAL (C62)	B. MED (C63)	C. JAIL (C64)	D. STRT (C65)	E. HOME (C66)	TIMES
0	0	0	0	0	None
1	1	1	1	1	One
2	2	2	2	2	2,3
3	3	3	3	3	4,5
4	4	4	4	4	6-9
5	5	5	5	5	10-14
6	6	6	6	6	15-19
7	7	7	7	7	20-29
8	8	8	8	8	30+
9	9	9	9	9	DK/NA

24. LEGS

What is the longest amount of time--

A. You were ___ continuously without kicking or quitting? ....

B. You were off ___ completely but not in an institution? ....

C. "A" & "B": You worked at a regular job while ___ ? ...

A. ON (C67)	B. OFF (C68)	C. JOB (C69)	TIME
0	0	0	None
1	1	1	1-6 days
2	2	2	1-3 weeks
3	3	3	1-2 months
4	4	4	3-5 months
5	5	5	6-11 months
6	6	6	1-2 years
7	7	7	3-5 years
8	8	8	6+ years
9	9	9	DK/NA

25. USERS KNOWN

A. About how many (drinkers)(drug users) (smokers) do you know well enough to say hello to? .... _ _ _ (C70-72)

IF ANY:
B. About how many of them are (alcoholics) (addicts) (tobacco addicts)? .... _ _ _ (C73-75)

26. AGE BENCH-MARKS

For each of the following things, if you have ever done it, please tell me how old you were when you did it for the first time.

	AGE	NEVER	DK	NA	
A. Tried smoking	_ _	00	98	99	(D 6- 7)
B. Tried a drug or a reefer	_ _	00	98	99	(D 8- 9)
C. Learned about drugs from friends	_ _	00	98	99	(D10-11)
D. Tried drinking	_ _	00	98	99	(D12-13)
E. Had sexual intercourse	_ _	00	98	99	(D14-15)
F. Got in trouble in school	_ _	00	98	99	(D16-17)
G. Got in trouble with the police	_ _	00	98	99	(D18-19)
H. Did any stealing	_ _	00	98	99	(D20-21)
I. Did any fighting with gangs	_ _	00	98	99	(D22-23)

27. ALIENATIONS

We all live under a system that tries to control us in what we should do or should not do.

A. In what ways do you go against the system (offend the system)? Do you: Break the law? Cheat or lie? Use violence? Have ideas or opinions that are not popular?)

B. In what ways does the system go against you (offend you)?

28. DEVIATIONS: SKIDDING, A-E AND HUSTLING, F-N

For each of the following please tell me if you have done it Recently, meaning in the past six months or so, or only Before that, or Never.

	REC.	BEF.	NEV.	NA	
A. Being without any clean clothes to wear	3	2	1	0	(D24)
B. Asking a stranger for some money	3	2	1	0	(D25)
C. Going without eating for a day or more	3	2	1	0	(D26)
D. Being without a bed to sleep in	3	2	1	0	(D27)
E. Being bothered by a cop	3	2	1	0	(D28)
F. Gambling	3	2	1	0	(D29)
G. Running numbers	3	2	1	0	(D30)
H. Pimping or prostituting	3	2	1	0	(D31)
I. Hold up or mugging	3	2	1	0	(D32)
J. Stealing or fencing	3	2	1	0	(D33)
K. Forgery or conning	3	2	1	0	(D34)
ASK L-N FOR "B" ONLY					
L. Pushing drugs	3	2	1	0	(D35)
M. Copping for someone else	3	2	1	0	(D36)
N. Lending works	3	2	1	0	(D37)

PART III

29. JOB STATUS

A. What do you do now--work full time, work part time, look for work, or what?

(D38) JOB STATUS
1 Full-time
2 Part-time
3 Looking
4 School
5 Housework
6 Illegal
7 Nothing
8 Other:
0 NA

30. OCCUPATIONS: IF NOT FAMILIAR, PROBE TITLE, FIELD, DUTIES.

A. What kind of job do you have now (did you have last--when was that)?

B. What kind of job have you had most often in the past?

C. What kind of job would you like to have in the future?

D. What kind of work did your father do when you were about 16?

IF R IS SINGLE, SKIP E.
E. What kind of work does (did) your wife (husband) do?

F. How do you think you will do in the future as far as jobs are concerned--Better, about the Same, or Worse than now?

(D39) F.JOB FUTURE
1 Better
2 Same
3 Worse
4 Other:
5 DK
0 NA

G. Were you ever in military service? (Were you honorably discharged?)

(D40) G.MILITARY SVC
1 Yes, hon.
2 Yes, not hon.
3 No service
4 DK
0 NA

A. LATEST (D41-42)		B. MODAL (D43-44)		C. FUTURE (D45-46)		D. FATHER (D47-48)		E. SPOUSE (D49-50)		JOB CLASS		JOB RANK	
1	1	1	1	1	1	1	1	1	1	Professional	1	1	WC Hi
2	2	2	2	2	2	2	2	2	2	Managerial	2	2	WC Mid
3	3	3	3	3	3	3	3	3	3	Clerical	3	3	WC Lo
4	4	4	4	4	4	4	4	4	4	Sales	4	4	BC Hi
5	5	5	5	5	5	5	5	5	5	Craftsman	5	5	BC Mid
6	6	6	6	6	6	6	6	6	6	Operative	6	6	BC Lo
7	7	7	7	7	7	7	7	7	7	Pvt.H.Wkr.	7	7	Other
8	8	8	8	8	8	8	8	8	8	Service	8	8	DNA or none
9	9	9	9	9	9	9	9	9	9	Laborer	9	9	DK
0	0	0	0	0	0	0	0	0	0	Coded right	0	0	NA

31. EMPLOYMENT CHART: INCLUDE ANY TIME FOR EDUCATION OR MILITARY SERVICE

A.WHAT What was the first (next) type of job you had?	B.WHEN When to when?	C.WHERE Where was that?	D.PAY What was the pay?	E.WHY LEAVE Why did you leave?
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....

F. Which of the jobs you have had did you like the most? Why?

G. Which did you dislike? Why?

32. EMPLOYABILITY	YES	NO	DK	NA	
A. Do you have anything wrong with you physically that would make a difference in finding or keeping a job? IF YES, What is that?	1	2	3	0	(D51)
B. Do you have any special abilities or interests that could help you now or later on a job? IF YES: What is that?	1	2	3	0	(D52)
C. Have you had any thoughts or plans about getting more schooling or job training for yourself in the future? IF YES: What are they?	1	2	3	0	(D53)

33. INCOME ITEMS

A. How are you supported now--from what sources does the money come that you are living on?

....

....

IF ONLY ONE SOURCE, SKIP B.

B. Which is the main source?

....

A.ALL (D54)mp	B.MAIN (D55)	INCOME SOURCES
1	1	Own earnings
2	2	Own savings
3	3	Own illegal acts
4	4	Welfare
5	5	Other disbursement(s)
6	6	Shared family income
7	7	Help from family
8	8	Help from other(s)
9	9	Other
0	0	NA

C. What was your family* income last year before any deductions?
*INCLUDE SPOUSE WHO IS IN HOUSEHOLD OR PARENTS OF DEPENDENT CHILD. $........

D. What is the largest yearly (family) income you have ever had? $........

E. Which year was that? ....

C.LAST (D56)	D.MOST (D57)	INCOME
0	0	Under 1000
1	1	1000-1999
2	2	2000-2999
3	3	3000-3999
4	4	4000-4999
5	5	5000-5999
6	6	6000-7999
7	7	8000-9999
8	8	10000 or more
9	9	NA

F. Do you owe any money now?
IF YES, PROBE DETAILS

(D58) F.DEBT
1 Yes 2 No 0 NA

34. DWELLINGS

A. How long have you lived in New York City? __ __ yrs. (D59-60)

B. How long have you lived at your present address? __ __ yrs. (D61-62)

IF B = 5+, SKIP C.

C. How many different addresses have you had in the last 5 years? (INCLUDES INSTITUTIONS)

(D63) ADDRESSES 5 8 8+:
1 3 6 9 DK
2 4 7 0 NA

D. What kind of place are you living in now? Is it a furnished apartment, or an unfurnished apartment, or what?

(D64) RESIDENCE TYPE
1 Pvt. house 6 Dormitory
2 Unfurn. apt. 7 Hotel
3 Furn. apt. 8 No steady place
4 Lodgings 9 Other:
5 Rooming hse. 0 NA

E. How many rooms are there where you live?

(D65) ROOMS 5 8 8+:
1 3 6 9 DNA
2 4 7 0 NA

F. How many people live in those rooms, including you?

(D66) PEOPLE 5 8 8+:
1 3 6 9 DNA
2 4 7 0 NA

IF ONE, SKIP G.

G. How are the others related to you?

....

....

H. How much is the entire rent for the place where you live?

$ .... per ....

(D67) RENT/MO. 7 150+
1 to 40 4 80-99 8 DNA
2 40-59 5 100-124 9 DK
3 60-79 6 125-149 0 NA

I. How much of that rent do you pay? IF LESS THAN ALL: Who (else) pays the rent?

....

J. What do you think of the place you live in now--would you call it excellent, good, fair, or poor?

(D68) PLACE EVAL.
1 Excellent 4 Poor
2 Good 5 DK
3 Fair 0 NA

K. How does it compare with most of the other places you've lived in?

(D69) PLACE COMP. 3 Worse
1 Better 4 DK
2 Same 0 NA

(D70) L. RMS/PERS
1 < .25 6 1.0 - 1.4
2 .25 - .32 7 1.5 - 1.9
3 .33 - .49 8 2.0 - 2.9
4 .50 - .74 9 3.0 +
5 .75 - .99 0 NA

(D71)mp M. H.H. COMP. REL. TO R.
1 Spouse 6 Sib(s)
2 Minor ch. 7 Other kin
3 Adult ch. 8 Non kin
4 Father 9 R. alone
5 Mother 0 NA

35. GEOGRAPHIC

A. Where were you born? ....

B. Where was your father born? ....

C. Where was your mother born? ....

IF NON-USA IN A-C, SKIP D.

D. Where were your grandparents born?

(Father's parents) ....

(Mother's parents) ....

R (D72)	F (D73)	M (D74)	SUM (D75)	BIRTH PLACE
1	1	1	1	USA
2	2	2	2	PR
3	3	3	3	O.Lat.Am.
4	4	4	4	N.Eur.
5	5	5	5	E.Eur.
6	6	6	6	W.Eur.
7	7	7	7	S.Eur.
8	8	8	8	Other
9	9	9	9	DK
0	0	0	0	NA

(D76) GEN.

1 I	3 III
2 II	4 IV +
	0 NA

E. In which NYC neighborhood or other place did you live mostly, to age 16? PROBE ENOUGH TO CODE AT RIGHT; ENTER ON LINE 1 IN GEOGRAPHIC CHART BELOW.

(D77) UPBRINGING TO 16

1 NYC	3 Town (1-10,000)
2 Other city (10,000+)	4 Village; farm
	0 NA

36. GEOGRAPHIC CHART: BY NEIGHBORHOOD, CITY, OR REGION

A.WHERE Where did you live (next)?	B.WHEN From when to when?	C.HOW LIKE How did you like it there?	D.WHY LEAVE Why did you leave?
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....

37. RELATIVES AND FRIENDS

PARENTS	A. Up to age 16, were you raised by both your mother and your father living together?	(E 6) PARENTS TOGETHER AT 16 1 Yes 2 No 3 DK 0 NA
	B. Are both your parents alive and living together now?	(E 7) PARENTS TOGETHER NOW 1 Yes 2 No 3 DK 0 NA
	IF NO TO A OR B, PLACE NATURAL, SUBSTITUTE &/OR STEP-PARENTS:	(E 8)mp LIVING NOW [STEP = +2] 1 Father 2 Mother 3 4 0 NA
SIBLINGS	C. How many brothers and sisters have you had (INCL HALF OR STEP)? IF NONE, SKIP D.	(E 9) SIBLINGS 4 7 0 2 5 8 8+: 1 3 6 9 NA
	D. Were you the oldest, the second oldest, or what?	(E10) BIRTH ORDER 2 First 4 Last 1 Only 3 Middle 0 NA
SPOUSES	E. How many times have you been married? IF NEVER, SKIP F & G.	(E11) MARRIAGES 4 0 2 5+: 1 3 NA
	F. How old were you when you were (first) married?	(E12) AGE 1ST MARRIED 5 30-34 8 50+ 1 To 14 3 20-24 6 35-39 9 DNA 2 15-19 4 25-29 7 40-49 0 NA
	G. How many years ago was your (last) marriage?	(E13) YRS LAST MAR. 5 10-14 8 30-39 1 To 1 3 3-5 6 15-19 9 40+ 2 1-2 4 6-9 7 20-29 0 NA
CHILDREN	H. How many children have you had?	(E14) NO. OF CHILDREN 4 7 0 2 5 8 8+: 1 3 6 9 NA
	I. Are you now expecting to become a parent (again)?	(E15) EXPECTING CHILD 1 Yes 2 No 3 DK 0 NA
FRIENDS & OTHERS	J. How many relatives, outside your immediate family, have been close to you?	(E16) OTHER REL. CLOSE 4 7 0 2 5 8 8+: 1 3 6 9 NA
	K. How many people do you consider to be close friends of yours?	(E17) FRIENDS 4 7 0 2 5 8 8+ 1 3 6 9 NA
	L. Outside of relatives and friends, how many people have taken a real interest in how you get along?	(E18) INTERESTED 4 7 0 2 5 8 8+: 1 3 6 9 NA
	M. Do you have a special friend or fiancé that you live with or go with? IF YES, PROBE RELATION AND PLANS:	(E19) SPECIAL FRIEND 1 Yes, live with 3 No 2 Yes, go with 0 NA

38. PERSON CHART: *IN D, MS = MARITAL STATUS, TO BE ASKED IF NOT CLEAR

	A.RELATION TO R.	B.NAME What is your ____'s name?	C.LOCATION Where is he (she) now?	D.A-MS* How old is ____?	E.WHAT DOES What does he (she) do?	F.HOW DOES How does he get along?
1.	....	....	....	....	....	....
2.	....	....	....	....	....	....
3.	....	....	....	....	....	....
4.	....	....	....	....	....	....
5.	....	....	....	....	....	....
6.	....	....	....	....	....	....
7.	....	....	....	....	....	....
8.	....	....	....	....	....	....
9.	....	....	....	....	....	....
10.	....	....	....	....	....	....
11.	....	....	....	....	....	....
12.	....	....	....	....	....	....
13.	....	....	....	....	....	....
14.	....	....	....	....	....	....
15.	....	....	....	....	....	....

G. Which persons have been important in your life? Why?

39. TRANSACTION CHART: FOLLOW-UP OF PERSON CHART

	A.WHO About ____:	B.WHEN SEEN When do (did) you see ____?	C.HOW GET ALONG WITH How do you get along with ___? (What do you do for each other? What do you do to each other?)
1.	....	....	....
2.	....	....	....
3.	....	....	....
4.	....	....	....
5.	....	....	....
6.	....	....	....
7.	....	....	....
8.	....	....	....
9.	....	....	....
10.	....	....	....
11.	....	....	....
12.	....	....	....
13.	....	....	....
14.	....	....	....
15.	....	....	....

40. REGISTRATIONS

Have you ever had any of the following things? Now, or only in the Past, or Never?

	NOW	PAST	NEVER	NA	
A. Driver's license	1	2	3	0	(E20)
B. Library card	1	2	3	0	(E21)
C. Credit card or charge account	1	2	3	0	(E22)
D. Checking or savings account	1	2	3	0	(E23)
E. Health or life insurance	1	2	3	0	(E24)

41. ORGANIZATIONS

Have you ever belonged to any of the following? Now, or only in the Past, or Never?

	NOW	PAST	NEVER	NA	
A. Nationality or hometown club	1	2	3	0	(E25)
B. Labor union	1	2	3	0	(E26)
C. Church or religious organization	1	2	3	0	(E27)
D. Political club	1	2	3	0	(E28)
E. PTA or parents' group	1	2	3	0	(E29)
F. Sports or social club or lodge	1	2	3	0	(E30)
G. Helping organization, like A.A.	1	2	3	0	(E31)
H. Any other kind of organization	1	2	3	0	(E32)

42. ORGANIZATIONS CHART

A.NAME What is the name of the ____ you belonged to?	B.WHEN When did you join (to when)?	C.WHERE Where is it located?	D.HOW ACTIVE How active a member are (were) you?
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....

43. PASTIMES

Which of the following have you done in the last month or so?

	YES	NO	NA	
A. Gone to a church or synagogue	1	2	0	(E33)
B. Gone to a party or a dance	1	2	0	(E34)
C. Gone out on a date (as a couple)	1	2	0	(E35)
D. Gone out to a movie or any kind of show	1	2	0	(E36)
E. Gone to a meeting of an organization	1	2	0	(E37)
F. Read a book or magazine	1	2	0	(E38)
G. Watched TV	1	2	0	(E39)
H. Made anything as a hobby	1	2	0	(E40)

I. TOTAL OF "YES" RESPONSES 0 1 2 3 4 5 6 7 8 9 (E41)

44. TIME ALLOTMENTS

Here are some of the main things that people do with their time. For each one, please tell me how many hours you spent at it during the average day, over the last month or so --just your quick estimate.

A. Sleeping _ _ (E42-43)
B. Eating _ _ (E44-45)
C. Doing chores at home _ _ (E46-47)
D. Working at a job (school) _ _ (E48-49)
E. Other things for money _ _ (E50-51)
F. Going to & from work _ _ (E52-53)
G. Other moving around _ _ (E54-55)
H. Leisure by yourself _ _ (E56-57)
I. Leisure with others _ _ (E58-59)
J. TOTAL HOURS _ _ (E60-61)

45. R'S SUNDAY: IF IT WAS A WORK DAY, ALSO ASK ABOUT R'S "LAST DAY OFF"

A. How did you spend the day last Sunday? When did you get up? What happened next? COVER SEQUENCE OF EVENTS TO BED TIME.

B. Was that about an average Sunday for you, or better or worse than average? (Better or worse, how?)

46. COLLATERAL CONTACTS: GET ADDRESSES OF SUGGESTED OR PERMITTED CONTACTS

As part of our program, we often find that it helps to get in touch with people like your family, friends, employers, agencies or professionals who know you. Please tell me how you would feel about that at this time.

47. CLOSE OF INTERVIEW

A. Thank you for this interview. Do you have any comments or any questions?

B. HAVE R SIGN RELEASES.

C. ENTER TIME OF CLOSE: .... a.m. p.m.

D. INTERVIEW WAS:	E.SUM D (E62)	F.START (E63)	G.1/3 HRS (E64)
[1] 1 MEETING	0	1 to 9 AM	1
___ NO ___ YES	1	2 9-10	2
	2	3 10-12	3
[2] CONTINUOUS	3	4 12-2	4
___ NO ___ YES	4	5 2-4	5
	5	6 4-5	6
[4] AT OUR HQ	6	7 5-7	7
___ NO ___ YES	7	8 7-9	8
	8 NA	9 9 PM +	9 3 hrs +
		0 NA	0 NA

H. EXPLAIN EACH NO IN ITEM D ABOVE:

48. INTERVIEWER'S DESCRIPTION: R'S APPEARANCE AND BEHAVIOR; WHO WAS WITH R.

49. INTERVIEWER'S RATINGS

A.CORPULENCE (E65)	B.GROOMING (E66)	C.GOOD LOOKS (E67)	D.DICTION (E68)	E.COHERENCE (E69)	F.TENSENESS (E70)	G.SOCIAL CLASS (E71)	RATING CATEGORIES
1	1	1	1	1	1	1	Far above
2	2	2	2	2	2	2	Above
3	3	3	3	3	3	3	Average
4	4	4	4	4	4	4	Below
5	5	5	5	5	5	5	Far below
0	0	0	0	0	0	0	NA

50. INTERVIEWER'S COMMENTS

N.B. COMPLETE QUESTION 3 ON PAGE 1.

APPENDIX C
CASE HISTORIES

INTRODUCTION

A number of different goals have been borne in mind in the selection and presentation of these case histories. Foremost has been our aim to demonstrate the community mental health philosophy in action. Another consideration has been to allow the reader to put into practice the diagnostic and evaluative procedures described in this manual. Consequently, several cases are presented but no prescription is offered; it is left to the reader to decide what might be done. In all cases, of course, the reader is invited to imagine what might be done *next,* or to construct alternatives to action already taken.

It is probably impossible to present a satisfactory cross section of all the "kinds" of cases seen in practice. We have, however, attempted to select cases showing a wide range of characteristics. Some are cases involving individuals in treatment; in some, the intervention target is at the organizational level. The individuals involved show widely varied social backgrounds, substance use histories, and routes by which they came to the attention of the community mental health agency referred to as "we" (the Division of Community Mental Health of New York Medical College). But rather than using these histories in attempting to define the kinds of individuals likely to be encountered in practice, we would have these cases used to illustrate the practice of an *approach* which can be useful in working with other cases as well.

Cases A through D were obtained as part of the study of Metropolitan Hospital staff and patients described in chapter III. They are chronological histories of the life-style adaptations of four drug users. The format is: first an outline, then a narrative section, then a summation. The individual's life is divided into phases relating to the particular focus of the study, that is, drug use. Each phase is characterized by a particular degree of involvement in conventional, criminal, and narcotic centered behavior; a chart showing changes in life style adaptation as measured by these variables is included with each case. It is to be noted that although at the time of interview the four individuals each represented a different life style adaptation type, adaptation is dynamic and changes through time.

Case E gives background material on a substance-using family, outlines the targets, goals, and methods chosen in the case, and describes the ongoing course of intervention.

Cases F through H illustrate community mental health intervention techniques on an other-than-individual level. The first two represent groups with whom we worked in mutual concern over a specific patient group. The third describes a formal Training Institute concerned with community mental health philosophy and practice.

CASE HISTORY A
OUTLINE

PERSONAL DATA

Sex, male; Age, 33; Ethnicity, Negro; Religion, Protestant; Education, 1 year high school; Gang membership, age 13–17 (vice president); Military service, Army (honorable discharge); Family, only child from a divorced family; Marital status, single.

FAMILY BACKGROUND

The patient's parents were separated when he was 8 years old. His father died when the patient was 12 years old, and his mother remarried 1 year later. The patient's mother has had a history of continuous suicide attempts since the patient was age 16. The patient was raised by his grandmother until he entered the Army at age 17, and it has been his grandmother to whom he has always turned in times of need. She has always bailed him out of jail.

The patient remembers that his father drank to excess, but that he had little conflict with his father. His major family conflict centered around his relationship with his mother. She is only 13 years older than the patient and he has been and continues to be ashamed of this. He verbalizes that she should be much older than this. Concomitantly a source of conflict arose from her many male friends that so often entered the home. The patient implied that his mother showed little interest in him, but indicated that his stepfather manifested great concern over him.

Patient's mother is a heavy alcohol user, as was his father. A cousin is a drug addict.

USE OF COMMUNITY RESOURCES

YMCA (swimming); church activities; Park Department (swimming and boxing); Harlem Hospital (hospitalized twice for pneumonia, once for broken jaw); Bellevue Hospital (treated for delirium tremens); GI Bill (TV repair training).

LEGAL INVOLVEMENT

Types of crimes: Pushing drugs; bootlegging whiskey; robbery; burglaries; breaking into cars; pocketbook snatching; policy numbers; and fencing.

Arrests: The patient has been arrested 28 times. He was arrested once for possession of policy numbers (at age 25, 30 days suspended sentence). He was arrested 16 times for selling bootleg whiskey (at ages 23-25 arrested 15 times, in jail 4 times and fined 11 times; at age 32, 30 days at Hart's Island). He was arrested 4 times on drug charges: age 21, possession of drugs, sentenced to 60 days at Riker's Island Penitentiary; age 22, possession of drugs, sentenced to 60 days at Riker's Island; age 28, selling drugs, charge dismissed after patient spent 2 months in the Tombs; age 31, possession of drugs, 3 years probation contingent upon the patient being admitted to USPHS Lexington. At age 33 the patient was arrested 3 times: twice for attempted robbery and once for violation of the Sullivan Act (carrying a knife in his pocket). The robbery charges were dismissed when the plaintiffs did not appear in court, and the violation of the Sullivan Act charge was dismissed also.

PHASES OF SUBSTANCE USE

Phase I (to age 20): The patient did not use any narcotic substances during this phase. He was not arrested or detoxified during this phase. He was the vice-president of a bopping gang (age 13-17). He began truanting at age 14. His parents separated when he was age 8; his father died when he was age 12; his mother remarried when he was age 13. His mother began the first of a series of suicide attempts when he was age 16. The patient joined the Army at age 17.

Phase II (age 20-23): The patient snorted heroin for 2 months and then began mainlining. He smoked marijuana occasionally. The patient was arrested for possession of narcotics twice. Each time, after kicking cold turkey in jail, he returned to drugs his first day in the community. The patient began his bootlegging activities.

Phase III (age 23-25): The patient continued mainlining heroin and smoking marijuana occasionally. The patient was arrested 15 times for his bootlegging activities. He kicked cold turkey 4 times in jail, and always returned to drugs on his first day in the community.

Phase IV (age 25-28): The patient continued to mainline heroin, smoke marijuana occasionally, and began to drink wine daily. The patient was arrested once for possession of narcotics, once for selling narcotics, and once for bootlegging.

Phase V (age 28-33): At age 29 the patient returned to skinpopping because he felt he had no veins left for mainlining. He continued to smoke marijuana occasionally and continued to drink wine daily. He was arrested once for possession of narcotics, once for selling narcotics, and once for bootlegging.

Phase VI (age 33—): The patient continued skinpopping heroin and began to use seconal. He smoked marijuana occasionally and continued to drink heavily. He was arrested twice for attempted robbery and once for violation of the Sullivan Act.

MEDICAL HISTORY

The patient was treated twice for pneumonia. He was treated once for delirium tremens. Psychiatric diagnosis is paranoid schizophrenia.

The patient has been detoxified 19 times: 13 times medically within institutions and 6 times cold turkey in jail. He has never kicked cold turkey on the streets. Of his 13 medical detoxifications, 6 have been voluntary (twice at Metropolitan Hospital, 1 AMA, 1 WMA; 3 times at Manhattan General Hospital, AMA; and once at Manhattan State Hospital, WMA). Seven times he was sent by the Court (5 times to USPHS, Lexington, WMA, and twice to Central Islip State Hospital, WMA). Every time he has been incarcerated, he has returned to drugs his first day in the community.

NARRATIVE

PHASE I (TO AGE 20)

Family. To the age of 20 the patient lived with his mother and father or stepfather in a three-room apartment in a "lousy" part of Harlem. The patient remembers that there was little closeness between his father and mother, and that his father drank to excess. The patient had a conflict-free relationship with his father and a conflict-ridden relationship with his mother. After his father and mother separated, the patient, at age 8, was often left alone in the apartment. The one person that the patient turned to was his grandmother who, from his description, he could always count on. The patient did whatever his grandmother told him to do, but rarely did what his mother asked him to do. At age 13 there was a change in his family role. His mother remarried and his stepfather manifested concern over him. He got the patient to join the YMCA and taught him swimming. During this phase the patient's mother began drinking, and when he was 16 years old she began what was to be an extensive history of suicide attempts. One such attempt that he remembers vividly occurred the night before he was to enter the Army.

School. Up to the age of 13, when the patient became a gang member, he was an honor student in school. He was fast in learning mathematics and was particularly interested in history. It would appear that school was not a challenge to his native ability, and he seemed quite bored with school. He started playing hookey at age 14, and at age 16 he quit school. "I got fed up with it." He also indicated that another major reason for quitting school was his fear of getting hurt there. He was one of two members of the Comanches going to his school, with the school being controlled by a rival gang. The patient indicated that while there was glamour in gang fighting, there was little glamour in school involvement. "My life was in the street."

Work. The patient had his first job at age 14. It was as an elevator relief operator, evenings. He worked at this for 1 year. His next job was in the Army, age 17–20. He was a corporal in the Quartermaster Commissary. In retrospect, the patient regretted not making the Army a career.

Friends. The patient remembered that he always had many friends. Up to the age of 13, when he became a gang member, he describes these friends as "squares." Upon joining the gang all of his friends were "slicksters." He pulled away from his square friends at this time. Irrespective of the type of friends he had, he remembers that friendship "went all the way."

Up to the age of 14, girls played no role in his life; his major interest was athletics. His interest in girls arose out of his gang membership. The girls he knew were part of the gang life. Members of his gang often called him "the runt" since they were aware of his bashfulness with girls. In reacting to this, he took great pleasure in instigating his fellow gang members to drop their girl friends. At no time during this period did the patient go steady.

Leisure Activities. Leisure time activities were rather limited during this phase. While he did go swimming at the local "Y" and both swam and boxed for the Park Department as a teenager, he tended to overlook these activities in evaluating his leisure time involvement. "Up to age 16, I had to be in at 9 o'clock and everything happened after 9 o'clock so I wasn't involved. After age 16 I became antisocial. I came in when I wanted to, but I now spent most of my time with gang members so I didn't have much of a social life."

Use of Community Resources.

The patient used the local YMCA for swimming; was involved in social and athletic activities at his church; and swam and boxed for the Park Department.

Illegal Activities. The patient began truanting at age 14, and at the same time joined the Comanches, a bopping gang. "I was the youngest and smallest member of the gang but I soon became vice president. I felt more important when I joined the gang; I got more recognition." Aside from his gang bopping activities, the patient was not involved in other delinquent or illegal activities.

Addict Involvement. The only addicts that the patient knew were some of his fellow gang members. Before going into the Army, he would see them during his daily gang activities. While in the Army, he would see them while on furlough. "I was a good touch for them because these were my gang members." The patient felt rather friendly toward these addicted gang members.

Support of Substance Use. The patient was not involved in substance use during this phase, and had no habit to support.

Summary. The patient's behavior during this phase can be categorized as moderate to high in conventional behavior, low to moderate in illegal behavior, and low in narcotic centered behavior.

PHASE II (AGE 20–23).

Family. After returning from the Army, the patient went back to live with his mother in a slum area in Harlem. His relationship with his mother continued to be conflict ridden and she, implicitly or explicitly, blamed her suicide attempts on him. During this phase, his mother continued her alcohol drinking. The patient continued to see his grandmother as frequently as he could and continued to feel that she was the only person who really cared about him and whom he could rely on.

School. The patient went to a television training school under the GI bill. He quit after 6 months because he felt that "all I did was nod all day."

Work. The patient had two jobs which he kept for one week each: working in a Chrysler parts department and as a carpenter's helper. He used drugs on both jobs.

Friends. From the patient's description, he did not feel that he had any friends during this phase, although he acknowledged having many acquaintances. "When you got money, you got friends." He would see these acquaintances numerous times during the week. While most generally his friends and acquaintances were either narcotic addicts or marijuana users, some of them he described as "9 to 5 workers," and some were involved in policy numbers. He was involved with two female addicts during this phase. These were short term involvements, since one of them went to jail on a charge of selling narcotics and the other went to Riverside Hospital for detoxification. Girls presented a problem for him during this phase. "I was lonely. I didn't have the right girl—the square girl. I felt shy with girls. I didn't know what to do with them, and I was envious of other fellows and their girls."

Leisure Activities. The major leisure time activity was partying. The patient did not have much time for an active social life since his criminal activities and his narcotic centered activities took up a great deal of time.

Use of Community Resources.

GI bill (training in TV repair).

Illegal Activities. The patient would see other addicts daily, but would "spend just a little time with them." Most of his friends and acquaintances, however, were either narcotic addicts or marijuana users. All of his heterosexual activities were with female addicts.

Support of Substance Use. The patient's primary drug throughout this phase was heroin, although he smoked marijuana also. The patient supported his habit through his illegal activities and, for the 2 weeks that he worked during this phase, through his salary.

PHASE III (AGE 2[illegible])

Family. The patient continued to live with his mother in the same apartment in Harlem. Whereas in the previous phase the patient had convinced his mother that her suspicions about his drug use were unwarranted, and she apparently went along in verbal collusion, she now argued with him almost daily about his drug use. From the patient's description, the major tie that bound him to his mother during this phase was her daily comments about his drug use. In retrospect, the patient attempted to view his relationship with his mother as being relatively tension free. "My mother couldn't give me a hard time because she wasn't supporting me." His grandmother, who did know of his drug use, quite openly supported it by giving him money whenever he ran short. He continued to feel quite close to his grandmother.

School. The patient did not attend school during this phase.

Work. The patient was not involved in any legitimate work during this phase.

Friends. The patient felt that he had no friends at all during this phase and very few acquaintances. The patient began to live a more and more secluded life during this phase. In part this was due to the energy and time that he put into supporting his habit. In part this was also due to his involvement, for 1 year, with a "square" girl. She knew of his drug use and was in many ways similar to his mother. "She was on my back for using drugs, while she herself was beginning to drink." After breaking up with her he met another girl who "dipped and dabbed" in drugs. "Soon after we met, I got her hooked." The patient went with her for the rest of the phase. The relationship ended quite impulsively. "My girl took a drug bust for me and she asked me to pick her up at the House of Detention. I didn't, so we broke up."

Leisure Activities. The patient was very minimally involved in leisure time activities during this phase. He infrequently went to parties and described himself as leading "more of a secluded life."

Use of Community Resources

None reported.

Illegal Activities. During this phase the patient engaged only in bootlegging activities. He was arrested 15 times for this.

Addict Involvement. The patient continued to see addicts daily, but spent less time with them than he had in the previous phase. While he acknowledged that the only people he now knew were addicts, he did not feel close to any of them.

Support of Substance Use. The patient continued to mainline heroin and smoke marijuana. He supported his habit through his bootlegging activities and with the money his grandmother gave him.

Summary. The patient's behavior during this phase can be categorized as low to moderate in conventional behavior, high in illegal behavior, and low in narcotic centered behavior.

PHASE IV (AGE 25–28)

Family. The patient moved out of his mother's apartment and went to live with his grandmother in the same area in Harlem. "My mother was getting on my nerves. She was going on binges about every 2 weeks and was on my back because of my drug habit." During this phase he did not see his mother as often as he had in the previous phase, but now saw his grandmother daily. She continued to give him money to support his habit. He continued to feel that his grandmother was the only person to whom he could turn.

School. The patient did not attend school during this phase.

Work. The patient did not work during this phase.

Friends. As in the previous phase, the patient continued to remain isolated from his peers and reported having no friends. A major interpersonal change during this phase was that for the first time he was not involved with any girls.

Leisure Activities. The patient remained uninvolved and isolated as far as leisure time activities were concerned. He no longer went to parties.

Use of Community Resources.

The patient was hospitalized at Bellevue Hospital at age 26 for delirium tremens.

Illegal Activities. The patient continued his bootleeging activities, and once again began pushing narcotics frequently. He was more involved in illegal behavior during this phase than in the previous one because he found that he was spending his money faster.

Addict Involvement. The patient continued to see addicts daily but spent very little time with them: "just enough to get high."

Support of Substance Use. The patient continued to mainline heroin, smoke marijuana occasionally, and began to drink wine quite heavily. He would consume a half gallon to a gallon of wine daily. The patient supported his habits through his illegal activities and, when he ran short of money, through the money that his grandmother gave him.

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, high in illegal behavior, and low in narcotic centered behavior.

PHASE V (AGE 28–33)

Family. The patient continued to live with his grandmother. Whereas the relationship with his grandmother remained the same during this phase as it had been in the past, there was a change in his relationship with his mother. He now saw her daily and felt that his mother was beginning to be understanding of him as a person, except for the area of his drug use. There still were many arguments between them about his use of drugs, but it would appear from his description that she was more accepting of him as a total human being, with drug use playing only a part in his behavior.

School. The patient did not attend school during this phase.

Work. The patient continued not to work during this phase.

Friends. The patient continued to be isolated interpersonally, having no friends and not being heterosexually involved. "I didn't go with any girls—I didn't care about girls. The ones I wanted I couldn't get, and I had a low opinion of other girls."

Leisure Activities. As in the previous phase, the patient was not involved in any leisure time activities.

Use of Community Resources. None reported.

Illegal Behavior. During this phase the patient stopped his bootlegging activities, continued pushing narcotics, and began his involvement in robberies.

Addict Involvement. The patient continued to see other addicts daily either to sell drugs to them or to get high. There were times, however, that he saw more of other addicts. This pertained to his involvement in robberies. "I'd see them if they were my crime partners." As in the previous phases, he did not feel close to any of his addict acquaintances.

Support of Substance Use. At age 29 the patient returned to skinpopping heroin, "because I had no veins left for mainlining." He smoked marijuana occasionally and continued to drink as much wine as he could get. The patient supported his habits solely through his illegal activities. "My grandmother no longer gave me money because she didn't have any to give."

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, high in illegal behavior, and low to moderate in narcotic centered behavior.

PHASE VI (AGE 33–)

Family. The patient continued to live with his grandmother, and continued to feel that she was the only one that he could depend on. "My grandmother is still behind me." The relative improvement in the patient's relationship with his mother during the previous phase began to disintegrate. "I didn't get along with my mother. She's always telling me to straighten up, but she's unwilling to help me." The patient no longer saw his mother on a daily basis.

School. The patient did not attend school during this phase.

Work. The patient did not work during this phase.

Friends. The patient continued to be isolated interpersonally. He had no male friends and was not interested or active in heterosexual relationships.

Leisure Activities. The patient continued not to be involved in any leisure time activities.

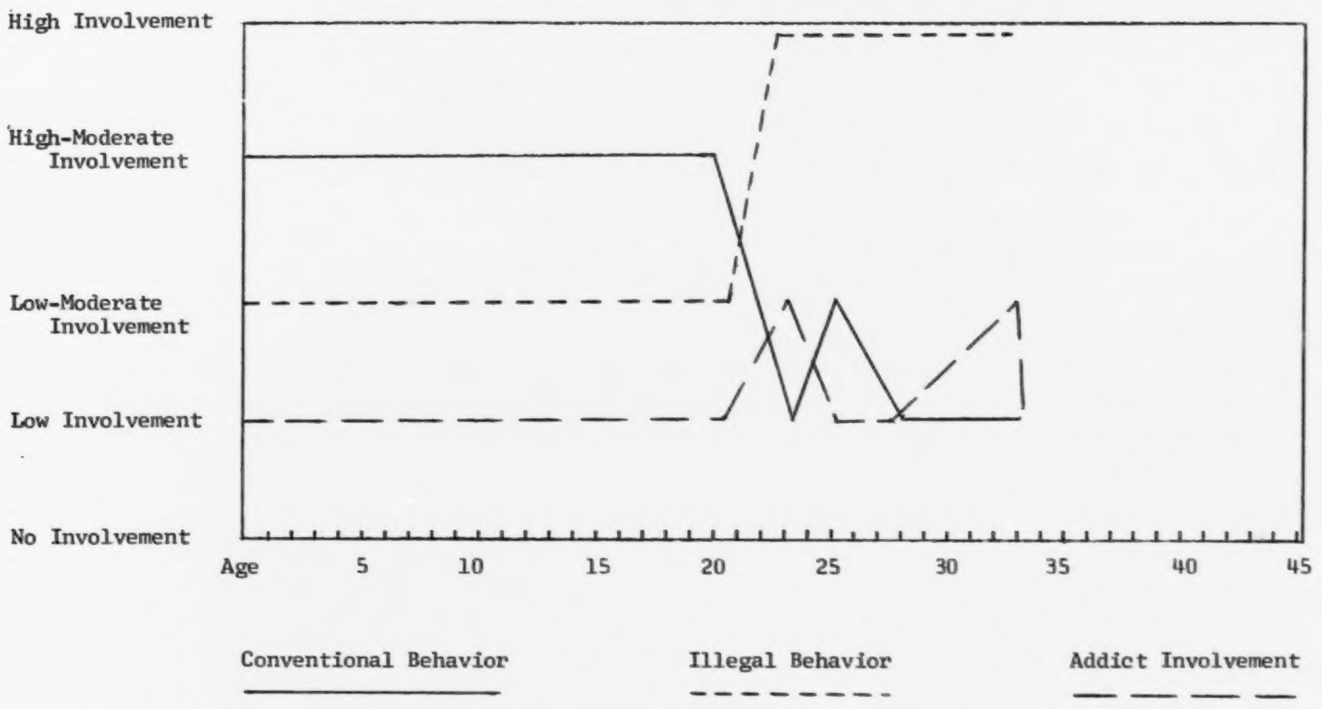
Use of Community Resources. None reported.

Illegal Activities. The patient continued to push narcotics and to be involved in robberies.

Addict Involvement. The patient continued to see addicts daily and indicated that "I took care of business first and then I'd split."

Support of Substance Use. The patient continued to skinpop heroin, smoke marijuana occasionally, drink wine daily, and began using seconals as boosters. His habits were supported solely through his illegal activities.

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, high in illegal behavior, and low in narcotic centered behavior.


CASE HISTORY A

SUMMATION

The patient's life style adaptation can be seen as changing from a moderate to high involvement in conventional areas of life prior to drug use, to an almost constant low degree of involvement subsequent to drug use; as a low to moderate involvement in illegal activities prior to drug use, changing to a consistent high degree of involvement subsequent to drug use; and as a relatively minimal involvement with other addicts both prior to and subsequent to his use of drugs.

Family. Prior to and subsequent to his use of drugs, the patient's relationship with his mother and father were generally conflict ridden, and he felt and continues to feel that the only one he can depend on is his grandmother with whom he has lived these last 8 years. Whereas his mother has generally harped on his use of drugs, his grandmother has constantly bailed him out of jail and, when she had money, given him money to help support his drug use.

School. Prior to his membership in a bopping gang he was an honor student. Subsequent to his gang involvement, which was prior to his use of drugs, he lost interest in school. He left after his first year of high school, never to return to any schooling.

Work. Prior to his use of drugs he was actively involved in the area of work. Subsequent to his use of drugs he has worked for only 2 weeks.

Friends. Prior to his use of drugs, and particularly when he was a member of a gang, he had many friends and felt close to them. Subsequent to his use of drugs he has become increasingly more isolated interpersonally, manifesting a decreasing interest in heterosexual relations.

Leisure Activities. Prior to his use of drugs, and while he was an active gang member, his involvement in leisure time activities was limited. Subsequent to his use of drugs he has become increasingly uninvolved and disinterested in leisure time activities.

Illegal Activities. Prior to his use of drugs his sole delinquent activity was gang bopping. Subsequent to his use of drugs he has maintained a high degree of involvement in illegal activities, although the variety of his activities has changed. He was actively involved in bootlegging during his first eight years of drug use; pushing drugs occasionally during his last 5 years of drug use, he became much involved in pushing drugs and then became increasingly involved in robberies.

Addict Involvement. Prior to his use of drugs he was friendly with fellow gang members who used drugs. Subsequent to his own use of drugs he has felt increasingly distant from them. During most of his history of drug use he spent very little time with drug addicts except during Phase V (age 28–33), when some of his addict acquaintances were crime partners.

Support of Substance Use. The patient's major source of support for his drug use has been his illegal activities. A secondary source of income was his grandmother.

CASE HISTORY B
OUTLINE

PERSONAL DATA

Sex, male; Age 28; Ethnicity, White (Italian); Religion, Catholic; Education, third-term high school; Gang membership, yes; Military service, none; Family, youngest of three siblings from an intact family; Marital status, single.

FAMILY BACKGROUND

The patient has lived with his family in the Greenwich Village area all his life. The patient has a brother 6 years older than he and a sister 3 years older. He remembers getting along well with his brother and sister, but also remembers a lot of tension in the home.

The patient's father, who was a truck driver, worked steadily, and died at home of a heart attack when the patient was 6 years old. The patient has very few memories concerning his father. He verbalizes concern over his past and present relationship with his mother. He felt that his mother was not sensitive to his needs. In describing his family, the patient indicated that his mother had seven siblings and that because of the large size of the family there tended to be "a lot going on at home." He remarked, however, that he never was at home and spent all of his time playing in the street. The patient felt that he "was sort of the maverick of the family." There were no other substance users in the family.

USE OF COMMUNITY RESOURCES

Bellevue Hospital at age 14 for psychiatric observation; Greenwich House and Village Aid Society for help with drug problem.

LEGAL INVOLVEMENT

Types of crimes: Stealing; burglary; pushing drugs; shoplifting; stealing and breaking into cars; and fencing.

Arrests: The patient has been arrested eight times: at age 18 for breaking into and entering a car, sentenced to Riverside Hospital by the Court; at age 19–20, six arrests for possession of narcotics, five times sentenced to 60 days in jail and once to 4 months; at age 21, felonious possession of narcotics, sentenced to 1½–5 years at Sing Sing, where he served 2 years.

The patient was picked up for violation of parole five times; at age 23, reinstated on parole; at age 25, returned for 1½ years to Sing Sing; at age 26, returned to Riker's Island Penitentiary once and the Tombs once; and lastly, his parole officer sent him to USPHS, Lexington, from which he signed out after 8 days.

PHASES OF SUBSTANCE USE

Phase I (to age 15): The patient was not involved in any substance use during this phase. He was not arrested during this phase, although he was hospitalized at Bellevue for psychiatric observation after a history of truanting and setting fire to paper in a basket at school. The patient was a member of a semistructured neighborhood gang that was involved in gang wars and was also involved in petty theft. His father died of a coronary when the patient was 6 years old.

Phase II (age 15–18): The patient began smoking marijuana on weekends at age 15. This lasted for about 1 year. At age 16 he began snorting heroin for about 9 months and then skin-popped for about 1 year. He was not arrested or detoxified during this phase. He became actively involved in criminal activities.

Phase III (age 18–23): The patient began mainlining heroin. He kicked cold turkey seven times in jail. He always returned to drugs on his first day in the community. He was arrested eight times; for breaking and entering a car (sent to Riverdale Hospital, WMA); six times for possession of narcotics (five times sentenced to 60 days in jail and once for 4 months); once for felonious possession of narcotics (1½–5 years at Sing Sing of which he served 2 years). The family gave him up as "hopeless."

Phase IV (age 23–26): The patient continued mainlining heroin. He was picked up for violation of parole twice; once being reinstated on parole and once being returned to Sing Sing for 1½ years. The patient kicked cold turkey in jail once.

Phase V (age 26—): The patient decreased his use of heroin. He initially switched to doriden and used heroin to counteract his sleepiness, which he attributed to doriden, and then began using dilaudid. The patient was detoxified medically 6 times (Manhattan State, AMA; Metropolitan Hospital four times, AMA: USPHS Lexington, AMA) and kicked cold turkey three times in jail and once at Bellevue Hospital. He always returned to drugs his first day in the community. The patient was picked up for violation of parole three times: sentenced to Riker's Island Penitentiary once; the Tombs once; and once his parole officer sent him to Lexington, from which he signed out after 8 days.

MEDICAL HISTORY

Patient has had no major physical illnesses. Psychiatric diagnosis is sociopathic personality.

The patient has been detoxified 17 times: 7 times medically (Riverside Hospital, WMA; USPHS Lexington, AMA: Manhattan State Hospital, AMA; Metropolitan Hospital, 4 times AMA); and 10 times cold turkey (jail, 9 times, Bellevue Hospital, once). Once the patient was administratively discharged after being in Manhattan General Hospital for 4 hours because he "caused a disturbance." "I was black-balled. I couldn't get in no more." The patient has always returned to drugs on his first day in the community.

NARRATIVE

PHASE I (TO AGE 15)

Family. The patient lived with his family in a four-room apartment in Greenwich Village in "a rather nice neighborhood." During this phase, the patient's contacts with members of his family (mother, brother, and sister) were minimal. He felt that he got along relatively well with his brother and sister, but rather poorly with his mother. Most of his available time was spent away from home, in the street. From his description, he was a recipient of little familial supervision.

School. The patient remembers himself as being a poor student in school. He suggested that he was not sufficiently challenged and motivated by the school material. The patient started truanting in his first year of high school. During the same period, at age 14, he was sent to Bellevue Hospital for setting fire to paper in a basket in school. He remained in Bellevue Hospital for one month and then returned to school.

Work. The patient had no work history during this phase.

Friends. The patient remembered having many good friends during this phase. By and large, these friends were male and he would see them daily. His attachment to these friends was rather strong. "I wasn't much interested in girls. I had no sex up to the time I was 15." The issue of girls was a major concern during this phase. In describing his social life he stated, "If you want to exclude girls, I had a ball. I felt that I couldn't compete with other fellows for girls."

Leisure Activities. The patient's major activities during this phase were sitting around with his friends and talking. He was not involved in any formal organizations, athletic groups, church groups or extracurricular school activities, neither did he "party" a lot. Part of his leisure time activity was delinquent in nature (breaking into stores for the fun of it).

Use of Community Resources. The patient was sent to Bellevue Hospital at age 14 for psychiatric observation.

Illegal Behavior. The patient's behavior during this phase can best be described as delinquent, not illegal. At age 14 he began truanting and acting out in school. Although the patient was not a member of a gang, he was a member of a semistructured neighborhood street group which often "got into minor wars with guys around the corner."

He and a number of his friends stole some dynamite from a neighborhood construction site. He smilingly commented that he was very happy that the dynamite had no caps. The patient was also involved in a series of petty thefts in which he and friends of his broke into neighborhood stores. It should be stressed, however, that these were activities with friends and not within the framework of a gang.

Addict Involvement. The patient did not have any addict friends.

Support of Substance Use. The patient was not a substance user during this phase, and did not have a habit to support.

Summary. The patient's behavior during this phase can be categorized as low to moderate in conventional behavior, low in illegal behavior, and no involvement in narcotic centered behavior.

PHASE II (AGE 15–18)

Family. The patient continued to live with his sister, brother, and mother in the same apartment. He describes the household as being very tense during this period. The patient felt that his mother was not sensitive to him and to his problems. "She felt that all I had to do was to get a job and everything would be okay." The patient felt that his family was on his back most of the time. As in the previous phase, the patient spent little time at home.

School. At age 16, when he was able to do so, he dropped out of school.

Work. During this phase the patient had five jobs. He worked as an unskilled laborer in all of them, and he never stayed at a job for more than 2 weeks. He was always using heroin while he worked.

Friends. During this phase, his previous neighborhood friends (who had turned to narcotics) continued to be his only friends. "I was tight with them at that time." These were the same friends with whom he had begun smoking marijuana at age 15. There were no heterosexual involvements during this period. "I couldn't think about girls then." His relationships and activities with his friends centered around the use of narcotics.

Leisure Activities. The patient stated that during this phase he had no social life. His leisure time activities consisted basically of the illegal activities in which he was involved to support his habit, his use of heroin, and sitting around talking with addict friends.

Use of Community Resources. None reported.

Illegal Behavior. Unlike the previous phase in which the patient indicated delinquent activities were done for kicks, during this phase he began to become seriously involved in criminal activities in order to support his habit. These activities consisted of shoplifting, breaking into cars, burglary, and toward the end of this phase he began pushing narcotics. The patient continued not to belong to gangs.

Addict Involvement. The patient spent almost all of his available time with drug users. During this phase, these addicts were the friends he had grown up with in the neighborhood. He felt quite close to them, and his relationship with them seemed to be important to him.

Support of Substance Use. The patient smoked marijuana on weekends for 1 year, at age 15. From age 16 on, during this phase, heroin was the drug he used. The patient's narcotic habit was basically supported through his criminal activities. At times, however, he was unable to make enough money through these activities to support his habit and would turn to his mother. "When I screamed enough, my mother gave me money; I imagine she knew what it was for." When the patient was only smoking marijuana on weekends, he stated that he only needed one dollar a week, which he got from his family.

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, high in illegal behavior, and high in narcotic centered behavior.

PHASE III (AGE 18–23)

Family. The patient continued living at home with his mother and sister. His brother got married. His sister was supporting the family. The patient remembers that every once in a while his mother would get on his back; he attributes the rarity of this occurrence to the fact that his family was beginning to give him up "for hopeless." By and large the patient used his house just to sleep in. Whereas in the previous phases he had had a relationship with his sister, he no longer appeared to have one.

School. The patient did not attend school during this phase.

Work. The patient did not work during this phase.

Friends. The patient lost contact with his friends. He described the process in the following way: "You know how junky friends are—they beat their friends and I'd beat them." During this phase the patient tended to be relatively isolated from his previous male friends, and began going out with girls. He would do so when he had "enough stuff set aside and enough money to buy nice clothes and go out." Given these self-imposed restrictions, his dating was limited.

Leisure Activities. The patient stated that he had none. When this was discussed, it became apparent that he was not including dating as a leisure time activity, or the infrequent chats that he had with addicts. His description appears to be another indication of how isolated he felt.

Use of Community Resources. None reported.

Illegal Behavior. The two illegal activities that the patient was involved in at this time were pushing (which he continued to do from the previous phase) and making the connection for other pushers.

Addict Involvement. During this phase the patient spent all of his time with addicts; he was, however, less involved with them than he had been in previous phases. He did not consider any of them as friends.

Support of Substance Use. The patient continued to use heroin as his only drug. His habit was supported through illegal activities. On bad days (when he was unable to get enough money for his very large habit) he received money from his mother and sister. He felt that they knew what the money was for.

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, low in illegal behavior, and high in narcotic centered behavior.

PHASE IV (AGE 23–26)

Family. During this phase of the patient's life he lived at home, and there was a general worsening in his relationship with family members. "My family had given me up for hopeless." His mother continued to harp at him about his unemployment and continued to stress to him that work would be "the whole solution to my junk problem." His married brother had little to do with him.

The patient's relationship with his sister was inhibited by the fact that he felt that his use of narcotics and his behavior had "put a damper on her social life." His sister got married when the patient was 25 years old. The patient expressed the belief that she hadn't married earlier because "I wasn't home and she stayed home to support the family."

School. The patient did not go to school during this phase.

Work. The patient had one job during this phase. He worked in a liquor factory, putting the tax stamps on the bottles. He stayed on this job for a few weeks and quit when he returned to drugs.

Friends. The patient had even fewer friends in this phase than he had in the previous phases. He explained this in terms of "guys moved away from the neighborhood; guys took overdoses; and because of the many debts I owned." His heterosexual relationships changed during this phase. Whereas in the previous phase he had begun to go out with girls as long as he had a reserve of narcotics and sufficient money to go out, during this phase he became totally disinterested in girls when he had a drug habit. He also acknowledged that he felt "mixed up about girls" during this phase. By this he meant: "I didn't care about them." It was during this phase that he permitted himself for the first time to get involved with a girl. She was not a narcotics user and he felt that he loved her. He knew that she had been bisexual before he had met her and had indicated that he was the first man that she had gone steady with. The patient was going to marry her after he found out that he had made her pregnant. Another reason for his wanting to marry her was that he felt that they were very similar and could help one another. "We both had vices and we were trying to stop." One night he found her in a Lesbian bar. This precipitated the end of their relationship. "She was the first person I ever cared for. I lost my head and beat her up. A few days later she told me that she had lost the kid because of the beating. She left me."

Leisure Activities. The patient was minimally involved in leisure time activities. His major involvement was with his girl friend for the time that the relationship lasted. They would see other people occasionally, but would not go to parties or to dances.

Use of Community Resources. During this time, the patient went to Greenwich House and the Village Aid Society, both in the Greenwich Village area. As a drug addict, although he didn't seek help formally from either agency, he went in the hope of getting help about his problems and also in an attempt to kill time. He described his experience there by saying, "I was just going there. I didn't feel like a member."

Illegal Behavior. The patient's criminal involvement changed radically in this phase. He no longer pushed drugs and shoplifted only once in a while, since his barbiturate habit necessitated his having, at most, only $3 worth of pills a day. A secondary criminal activity was fencing.

Addict Involvement. The patient spent almost all of his available time with addicts. In explaining this he stated, "They are the only people you could spend this time with when you're using."

Support of Substance Use. During this phase, the patient switched from heroin use to doriden. He used both of these substances sequentially. "I took heroin only to take the sleepiness away from me." The change in substance use had the consequence of lowering his financial output for drugs. The patient supported his habit through his intermittent criminal activities and through money that he received from his mother and sister.

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, low to moderate in illegal behavior, and moderate to high in narcotic centered behavior.

PHASE V (AGE 26–)

Family. The patient continued to live at home with his mother. He felt that his family felt even more hopeless about him. He indicated that, during this phase, "They pray for me but nothing else." His contacts with his brother and sister were minimal. However, an aunt and uncle became involved with him. The extent of their involvement, however, entails giving him money for drugs.

School. The patient did not attend school during this phase.

Work. The patient did not work during this phase.

Friends. The patient reported that he had less friends during this phase then ever before. He appears to have become more isolated during this phase. His only friends are addicts; "non-addicts won't accept me."

His heterosexual relations have worsened since the termination of the relationship in the previous phase. He has not gone steady with anyone during this phase and notes that he knows "a few junky broads, but there's nothing to it."

Leisure Activities. The patient described himself as having had no leisure time activities or interests during this phase. His major activities with others seem to have been talking; he remarked that doriden tends to facilitate talking.

Use of Community Resources. None reported.

Illegal Behavior. The patient has continued to shoplift infrequently during this phase and has continued fencing. The patient remarked that he was much less involved in criminal activities than he had been in his two previous phases.

Addict Involvement. The patient continued to see drug addicts every day, but aside from one addict friend, he did not consider the others as friends.

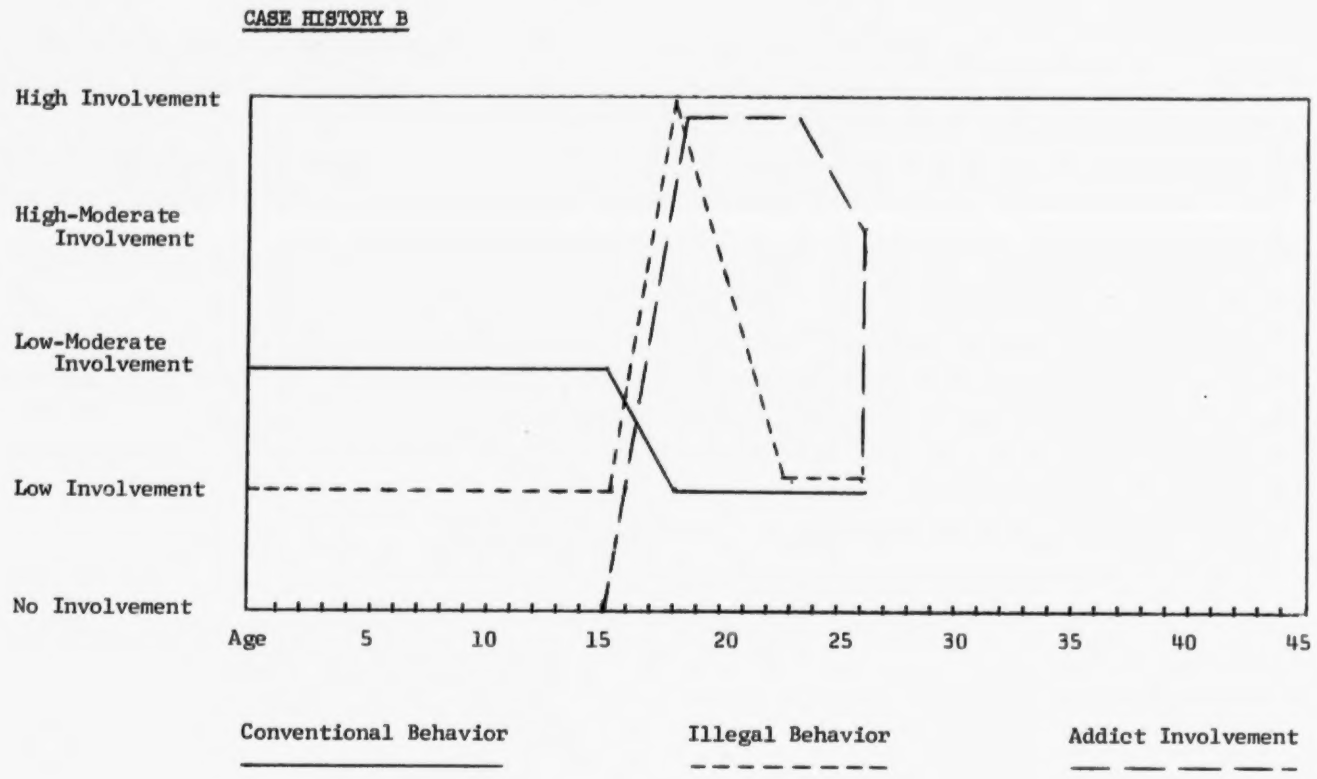
Support of Substance Use. The patient continued to use doriden throughout this period, using approximately 12 pills a day. Infrequently he would use heroin sequentially with it. He also used dilaudid at times. Since his doriden habit was a small one, he no longer found it necessary to be involved in criminal activities. "Most of my habit was supported by money coming from my mother and my aunt and uncle; they knew what the money was for."

Summary. The patient's behavior during this phase can be categorized as low in conventional behavior, low in illegal behavior, and low to moderate in narcotic centered behavior.

SUMMATION

The patient has been minimally involved in the conventional areas of family, school, work, friends and leisure time activities prior to his use of drugs (to age 15), during this period of heroin use (age 16–26), and in his present doriden phase (age 27). There has been a steady decrease in his involvement in conventional areas of life since he began using drugs.

This patient has never been highly involved in illegal behavior for a long period of time, although even prior to his use of drugs he got a kick out of boosting. During the 2-year period immediately after he began using drugs, he was highly involved in illegal activities, but there has been a steady decrease since then. While using drugs, his major areas of illegal involvement were pushing, shoplifting, breaking into cars and fencing for others. Since his primary drug has become doriden, for which he needs only $3 a day, he has become less and less involved in criminal activities.



Similarly, since his use of doriden, the patient has become less involved in narcotic centered behavior. When using heroin, he not only copped with addicts, stayed with them, and chatted with them, but also considered them to be friends of his. However, during his last two phases, although he has spent the same amount of time with addicts, he feels more isolated from them, and from others.

CASE HISTORY C

OUTLINE

PERSONAL DATA

Sex, male; Age, 22; Ethnicity, White (Cuban); Religion, Catholic; Education, high school graduate plus 2 years of evening courses in electrical engineering in a union school; Gang membership, none; Military service, none; Family, oldest of three siblings from an intact family; Marital status, separated.

FAMILY BACKGROUND

The family consists of a father, who works as an electrician; a mother, who has never worked; the patient, who is the oldest of three siblings; a brother 3 years younger, and a sister 5 years younger. From the patient's description, although it is an intact family, it never has been a closeknit one. Since the patient's childhood, there has never been a resolution of the conflict-ridden relationships manifested quite openly in this family. The patient stated that he has always felt close to his mother, but that he has had no relationship with his father. The patient concluded that the lack of relationship between him and his father was due to the fact that "maybe he felt that there was too much affection between me and my mother." The brother had a close relationship to the father which was analagous to that of the patient with his mother. The patient felt that because of this, "I didn't have much of a relationship with my brother. I guess it was because my mother always gave me more than she gave my brother and my brother resented it." The patient's relationship with his sister was quite close, and she seemed able to have a relationship with both her mother and father, although the patient described her as having a closer relationship with their mother.

The conflicts that arose from the divided loyalties in the family were worsened by the father's rather regular alcohol abuse, and the mother's having the final say in all family matters. The patient's sister went to church regularly; his mother went frequently; his father went occasionally; and the patient and his brother went very infrequently, although the patient did attend a parochial grammar school. The patient remembers his family as rarely going anywhere together as a family, and rarely visiting other family members in New York.

Major illnesses in the family include father's ulcers which he developed when the patient was 20 years old. Mother has had diabetes since before the patient was born.

The father was a heavy alcohol user up to 5 years ago. A cousin is a drug user.

USE OF COMMUNITY RESOURCES

Towns Hospital (to "dry out" the father, who was a heavy alcohol user); Knickerbocker Hospital (for treatment of patient's bronchial asthma and treatment of his father's ulcers); Columbia-Presbyterian Hospital (for outpatient treatment of mother's diabetes); Hall-Kimball Hospital, Lakewood, N.J. (patient was hospitalized at age 9 for bronchial asthma); private physicians (for the treatment of the patient's bronchial asthma; the father's ulcers; and the patient's ulcers); patient and his father are members of the International Brotherhood of Electrical Workers, and patient attended a union supported school for 2 years; use of the local Democratic Club to get the patient into the Manhattan General Hospital.

LEGAL INVOLVEMENT

Types of crimes: Boosting; drug courier.

Arrests: The patient was arrested once at age 21 for possession of a set of works. He received a suspended sentence.

PHASES OF SUBSTANCE USE

Phase I (to age 18½): The patient did not use any narcotic substance during this phase. From age 13 to age 18, he drank beer on weekends, generally by himself, to get high. The patient's father drank heavily on and off during this phase.

Phase II (age 18½–20): The patient snorted heroin about twice a week during this entire phase. He smoked marijuana once or twice but stopped it. He rarely drank. The patient was detoxified four times (three WMA, one AMA). He always returned to drugs on the day of his discharge. The patient was not arrested during this phase. The patient married during this phase.

Phase III (age 20–): The patient skinpopped for 1½ years and then started to mainline heroin. At age 21½ he began using doridens as boosters. He rarely drank. The patient was detoxified eight times during this phase (two WMA, six AMA). He always returned to drugs on the day of discharge. The patient was arrested for possession of a set of works and received a suspended sentence. The patient's wife separated from him. The patient developed ulcers, as did his father.

MEDICAL HISTORY

Patient has had bronchial asthma since age 4, and developed ulcers at age 21. Psychiatric diagnosis is passive aggressive personality, dependent type.

The patient has been detoxified medically 12 times; he has never kicked cold turkey. The patient has been detoxified 4 times at Metropolitan Hospital (all discharges AMA); 3 times at Riverside Hospital (2 WMA, 1 AMA); twice at Towns Hospital (WMA); once at Gracie Square Hospital (WMA); once at Manhattan General Hospital (AMA); and once at USPHS Lexington (AMA). The patient has always returned to drugs the day he was discharged.

NARRATIVE

PHASE I (TO AGE 18½)

Family. The patient lived with his family, first in a four-room apartment and then in a five-room apartment around 130th Street and Broadway, in New York. During this phase the patient felt close only to his mother and to his sister, and he felt that he had no relationship at all with his father. In part he blamed this on his father's jealousy about his relationship with his mother. The patient did not feel close to his brother and blamed this on his brother's resentment that his mother always gave the patient more than she gave her other children. The patient considered his relationship with his sister to be a very close and very good one ("she looked up to me; she came to me with her problems").

During this period the patient's father, who was an electrician and a fairly good wage earner, abused alcohol rather regularly. After he had been drinking for about a week or so the family would hospitalize him; he would stay off alcohol for a time, then begin drinking to excess again and would be readmitted to the hospital. The father's drinking was a major source of tension in the family. Another source of tensions in the family were arguments by the parents about their children. The patient remembered that in all of these arguments his mother had the final say.

The mother never worked during this phase. In part this was due to her husband's being a good wage earner, and in part to her being a diabetic. The family's involvement with and commitment to religion and the church was individual and varied. The family rarely went anywhere together and rarely visited other family members in New York.

School. The patient went to a Catholic parochial grammar school, where he did "just passing work." He did not get involved in any of the religious or social activities in the parochial school. He had wanted to go to a military academy upon graduation from the parochial school, and the family sent him to Oakland Military Academy, from which he graduated at age 18. It cost the family $2,400 every 8 months for 4 years. At the Academy he did average work scholastically, but was very much involved in all sports and specifically in horseback riding. He participated in a number of horse shows for the Academy. In neither of these schools did the patient ever do homework. "I hated to do homework. My mother pushed me to do homework, and if it wasn't for her, I wouldn't have gotten a diploma. My father didn't push me at all."

Work. The patient worked as a delivery boy for a dry-cleaning store during the summer months, from age 16 to age 18, returning to the same job each summer.

Friends. The patient had three close friends with whom he had grown up. While in grammar school he would see them daily, and when at the Academy he would see them on weekends. He would often go out with them to dances, parties and movies. Aside from these close buddies, the patient stated that "a lot of other people knew me but I didn't know them. I didn't want to know them."

The patient began his heterosexual interests at age 11 when he started dating. His first sexual experience was at age 12. He would generally go steady for 3 weeks to a month and then break off the relationship, "because I'd lose interest."

Leisure Activities. The patient went to dances, parties and movies, and was involved in sports with his buddies. However, he described his favorite activity in the following manner: "Mostly though, I like to be by myself."

Use of Community Resources. The patient was treated at Knickerbocker Hospital and at Hall-Kimble Hospital in Lakewood, N.J., for bronchial asthma. His mother was treated at Columbia-Presbyterian Hospital for diabetes. His father was treated at Towns Hospital for alcohol use. The famliy was also using various private physicians for the aforementioned conditions.

Illegal Behavior. The patient was not involved in any illegal behavior during this phase.

Addict Involvement. "I saw some older guys in the neighborhood who I knew were using drugs, but they weren't friends of mine."

Support of Substance Use. The patient drank beer on weekends from age 13 to age 18 with the intention of getting intoxicated. He did not use any other substances. He supported his weekend beer drinking from money that he received from his mother.

Summary. The patient's behavior during this phase can be categorized as high in conventional behavior, with no involvement in illegal or narcotic centered behavior.

PHASE II (AGE 18½–20)

Family (primary). For the first 6 months of this phase the patient continued to live with his family. There were two major changes in his relationships with other family members: he felt closer to his sister than he had felt in the previous phase, and he felt more distant from his father. His relationships with his brother and his mother remained the same. It was during this phase that he began to feel that his parents remained married "out of duty." "My mother and father never went out together. They never seemed very close." Arguments increased between his parents during this phase, and his father was hospitalized once for alcohol abuse. Toward the end of this phase his father developed ulcers and was hospitalized for this.

Family (conjugal). At the age of 19 the patient married a Puerto Rican girl that he had known and dated for four years. She had had a 3-year high school education and worked as a doctor's assistant. She knew that the patient was using drugs and although she didn't like it, in the patient's words, "She didn't raise so much fuss about it."

The patient and his wife lived in a 2½-room apartment, a few blocks away from where his family lived. His marriage was not very well accepted by his family. "My mother was against my getting married. She just didn't want me to get married. Sometimes she was hard on my wife."

The patient was quite ambivalent in his feelings toward his wife. While he felt that he married her because he "loved her and wanted to be with her," he also felt that "she was behind me only sometimes." He described her as "always wanting others to make decisions for her." One of the sources of tension in this marriage was the patient's mother, who seems to be ever present in the patient's life.

School. After graduating from high school the patient began studying electrical engineering two nights a week in his union's school. He attended classes regularly and stated that "I enjoyed it somewhat."

Work. During this phase the patient worked as an electrician's apprentice for one foreman. He felt that the job was allright but, "I wasn't too wild about it. The only thing I liked about the job was that I learned new things every day; it wasn't monotonous." The patient used drugs while working.

Friends. The patient retained friendship with his three close buddies of the previous phase. He saw them less often now, only a few days a week rather than daily. He would go to dances with them, play ball with them, but mostly, "just hang around with them." Although married, he continued having a few steady girls during this phase. As in the past, no relationship lasted longer than 3 weeks.

Leisure Activities. The patient was less involved in leisure time activities than he had been in the previous phase. He would go to dances, play ball, go out with his wife, and putter around fixing cars.

Use of Community Resources. The patient's father was hospitalized at Towns Hospital once for alcoholism and at Knickerbocker Hospital once for ulcers. The patient became a member of the International Brotherhood of Electrical Workers, and attended their union school for 2 years, studying electrical engineering.

Illegal Behavior. The patient was not involved in any illegal behavior during this phase.

Addict Involvement. The patient knew about 20 addicts during this phase but only considered one of them a friend of his. He would see addicts daily but did not spend much time with them. "I'd cop and fly."

Support of Substance Use. He snorted only heroin during this phase. He supported his habit primarily through his salary, through infrequent borrowing from his mother, and through infrequent pawning. "If I pawned something, I'd take it out on the next pay day."

Summary. The patient's behavior during this phase can be categorized as moderate to high in conventional behavior, no involvement in illegal behavior, and low involvement in narcotic centered behavior.

PHASE III (AGE 20–)

Family (primary). During this phase, when the patient was not being detoxified, he lived a good part of the time with his family, particularly since his wife moved back to her folks when the patient was 21 years old.

The patient's family reacted quite individually to his drug use. The patient's mother felt very upset about the patient. "She felt that she had failed me in some way." While the patient's mother made all the arrangements for his hospitalizations up to age 21 and pushed the patient to go through with the hospitalizations, the patient's father paid the bills at the private hospitals, but never indicated to the patient how he felt about his son's use of drugs "My father had no feelings. It was like he wasn't there. If he had any feelings about me, he never told me. My relationship was nothing with him." The patient felt that his relationship with his sister had gotten closer during this phase, and he noted that his sister was very upset about his drug use. He described his sister, who had started college during this phase, as being the "brains of the family." His relationship with his brother remained about the same as it had been in the previous two phases.

When not in hospitals, he would see his family daily, and when hospitalized, only his mother and sister would visit him regularly.

Family (conjugal). For this entire phase the patient's marriage was an unending series of arguments. "The arguments were never really about my using drugs, but more about my being a husband. We were back living with my mother and my wife felt that we should have our own apartment and that I should go out to work. She was still working."

When the patient was 21 years old, his wife moved back to her folk's home. From the patient's description, it would seem that she hoped that this would trigger off some decisive behavior on his part. It did not. At the same time, she began drinking heavily and when she saw him she blamed her drinking on him. At age 21½, they were separated and the wife hired a lawyer to initiate divorce proceedings.

School. The patient continued to go to his union school for one half year at the beginning of this phase.

Work. The patient worked at seven jobs as an electrician's helper. He usually worked 2 or 3 weeks and quit. He would stay out of work a few weeks and then get another job. "It was like a merry-go-round." The patient used drugs on all of these jobs.

Friends. When not hospitalized, the patient continued seeing the same three childhood friends, who were nonusers. He would generally see them on weekends, whereas in the previous phases he would see them more often. While he still felt close to them, he engaged in fewer activities with them. "I just hang around with them. I very rarely go to a dance with them."

His heterosexual pattern changed during this phase. "Once in a while I date. I don't go steady because I don't have time for it."

Leisure Activities. The patient stated that he had "no leisure time." He was involved in "just hanging around when I would have time."

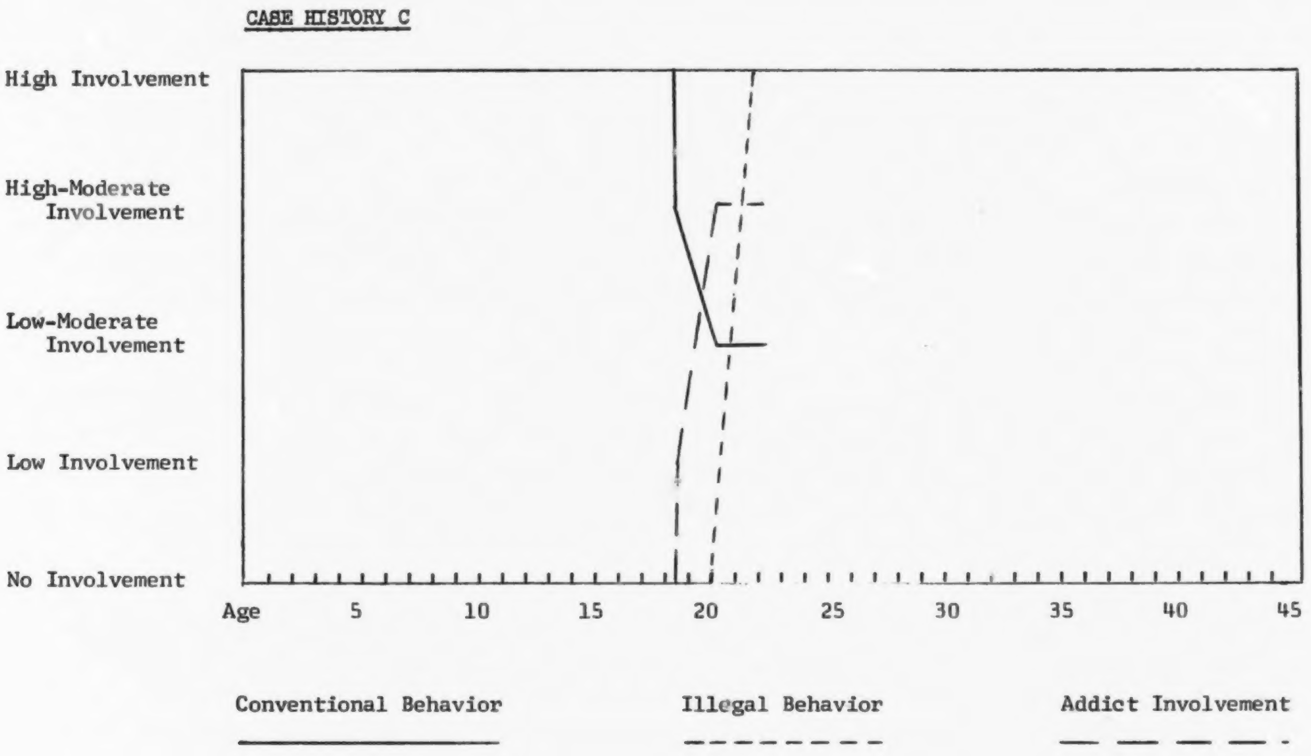
Use of Community Resources. Private physicians treated the ulcers that the patient developed during this phase. His mother continued being treated at Columbia-Presbyterian Hospital for her diabetes. His father continued being treated privately for his ulcers. His mother went to the local Democratic Club to try to get him into Manhattan General Hospital; he was admitted the same day. The patient continued to attend the union school of the International Brotherhood of Electrical Workers for 6 monhs.

Illegal Behavior. The patient began infrequent boosting during this phase. His major illegal activity was that of being a drug courier. He worked for a cousin who was a connection as well as a drug user, and the patient was paid $250 to $300 a week to make two or three deliveries. "I'd also snatch some stuff from each delivery. At age 21 he was arrested for possession of a set of works, but received a supended entence.

Addict Involvement. The patient knew more addicts during this phase than he had in the past. He considered one or two of them as being friends of his, and he would generally take off with them. He would see his addict friends and acquaintances daily, but his attitude toward them was as it had been in the previous phase: "I'd just cop and fly."

Support of Substance Use. The patient mainlined heroin during most of this phase, and in the last 6 months began using doridens as boosters. The patient supported his habit through his illegal activities, his salary when he was working, infrequent pawning, and money that he received from his mother infrequently.

Summary. The patient's behavior during this phase can be categorized as low to moderate in conventional behavior, high in illegal behavior, and moderate to high in narcotic centered behavior.



SUMMATION

The patient's life can be seen as consisting of a steady decrease in involvement in conventional areas of life, with a sudden and sharp increase in involvement in illegal activities and a relatively consistent increase in involvement with other addicts.

Family (primary). The patient's relationships to members of his family have remained relatively constant throughout his life: close to his mother and sister, distant from his brother, and conflict-ridden and very distant from his father.

Family (conjugal). Whereas the patient's marriage was not a stable one from its inception, as he began to become more involved in drug use and detoxifications, the relationship began to deteriorate even more until his wife finally left him. She herself turned to alcohol.

School. Both prior to and while he used drugs the patient was just minimally involved in school work.

Work. Prior to, and in the initial stages of his use of drugs, the patient worked regularly, although he was not very enthusiastic about his jobs. Since age 19, when the patient began his cycle of medical detoxification, he has quit one job after another. From the time he began using drugs, the patient has continued to use drugs while working.

Leisure Activities. There has been little change in his leisure time activities since he began using drugs. He has in the past been only minimally involved in leisure time activities, preferring to be by himself.

Illegal Behavior. Up to age of 20, even while using drugs, the patient was not involved in illegal activities. As he has become more and more involved in a drug life, he has begun to boost infrequently and to act as a drug courier.

Addict Involvement. From early adolescence on the patient has known a number of drug addicts. From the time he began using drugs up to the present time there has always been at least one addict that he considered to be a friend.

Support of Substance Use. Until he became involved in illegal activities, he supported his habit primarily through his salary and money that his mother gave him.

CASE HISTORY D

OUTLINE

PERSONAL DATA

Sex, male; Age, 41; Ethnicity, Puerto Rican; Religion, Catholic; Education, high school graduate; Gang membership, none; Military Service, none; Family, elder twin from an intact family of seven siblings (father and four brothers are deceased); Marital Status, married.

FAMILY BACKGROUND

The patient grew up in an intact family consisting of five brothers and one sister. He and his twin brother were the oldest siblings. Two brothers died in infancy, age 9 months and 18 months. Two brothers died in adulthood; one brother was stabbed to death in a bar (case of mistaken identity) when the patient was age 23, and the other died of wood alcohol poisoning when the patient was age 32.

The patient's twin brother became deeply involved in gambling at age 20½, began drinking heavily at age 23, smoking marijuana at age 24, and using heroin at age 25; and at age 24 the patient's twin brother was committed to a hospital for psychiatric care. This was the first of many commitments that were to follow.

The patient's father began drinking heavily when he began working for the Works Projects Administration (WPA) after being fired from his job as a department store carpenter which he had held for 11 years. Although the father drank daily, he never drank in front of the children and never let his drinking interfere with his work. The patient's father was committed to Rockland State Hospital in 1944. The patient was involved in this in that he himself drove his father to Bellevue Hospital after he intervened in an attempted stabbing and assault on his mother. Through the intervention of a cousin, who was a physician, the patient's father was transferred to Manhattan State Hospital, where he died of a heart attack in 1956.

The patient's father was a cabinet maker and carpenter and a good provider. The family was a close-knit one and quite religious. The family went to church regularly. The household was open to all the children in the neighborhood. The patient's mother would spend hours preparing fresh ice cream for them. Many of the fellows still come to see her, call her "Ma," send her Mother's Day cards, and visit her on Christmas and New Year's.

School was an important consideration in the household. The parents made sure that the children did their homework every night before they were permitted to go out on the street to play. The patient's mother made sure that her children had clean and pressed clothes for school.

The patient's father, a heavy alcohol user diagnosed as schizophrenic reaction paranoid type, died of a coronary in Manhattan State Hospital. Patient's twin brother has been diagnosed as having a schizophrenic reaction; this brother used drugs and alcohol extensively. Both younger brothers, now deceased, were drug users. Patient's common law brother-in-law is also a drug user.

USE OF COMMUNITY RESOURCES

Church (religious and social activities); state hospitals (for his father's psychiatric care); Municipal, State and VA hospitals (for his twin brother's psychiatric care); National Youth Administration (NYA); Merchant Marine Union School; savings bank; Notary Public school (to be licensed as a Notary Public); PTA; and Nurse's Aide training.

LEGAL INVOLVEMENT

Types of crimes: Passed bad checks; using credit cards; passing money orders; and passing prescriptions.

Arrests: The patient has never been arrested or, for that matter, picked up by the police.

PHASES OF SUBSTANCE USE

Phase I (to age 17): The patient did not use any substances during this phase, nor was he arrested during this phase. The patient's two youngest siblings died.

Phase II (age 17–29): The patient began heavy daily drinking at age 21, which tapered off to social drinking at the end of this phase. About the same time that he began drinking, he also became very involved in gambling. This also tapered off at the end of this phase. The patient married at age 21. At age 22, his father was committed to Rockland State Hospital. At age 24, his twin brother began using drugs. At age 23, one of his brothers was stabbed to death in a bar. At age 24, his son was born from his legal marriage.

Phase III (age 29–32): The patient began smoking marijuana on weekends with non-drug using friends. He rolled his own marijuana. He has continued to smoke marijuana since then, but not on a regular basis. The patient drank socially and gambled infrequently. The patient met his common-law wife and a daughter was born to them. The patient was not arrested during this phase.

Phase IV (age 32–37): The patient continued smoking marijuana irregularly, drinking socially, and gambling infrequently. The patient became involved in working at five jobs simultaneously. The patient's father died at Manhattan State Hospital of a heart attack and his other brother died of wood alcohol poisoning.

Phase V (age 37–40): At age 37 the patient began snorting heroin for a short period of time, skinpopped for 1 day and then began mainlining. At age 38, he began using doriden and at age 39, morphine. The patient was detoxified 10 times: 4 times medically in hospitals (twice at Metropolitan Hospital, WMA; twice at Manhattan General Hospital, WMA); twice with tranquilizers in the street under medical supervision; and 4 times cold turkey at his common-law wife's apartment. Twice he began detoxification in the streets under medical supervision but began using the dolophine as a booster with heroin. He obstained from drugs once for 6 months; once for 3 months; twice for 2 months; once for 6 weeks; and five times he returned to drugs his first day after kicking. The patient continued to drink socially, smoke marijuana infrequently, and gamble infrequently. The patient continued to maintain his marriage and his common-law relationship simultaneously.

Phase VI (age 40–): The patient used heroin as his primary drug and continued to use doriden and morphine. He began using demerol and dilaudid, tuinal and seconal. At age 40 the patient was detoxified once (Metropolitan Hospital, WMA), and abstained from drugs for 1 month. The patient continued to drink socially, smoke marijuana and gamble rarely. The patient continued his marriage and common-law relationship simultaneously.

MEDICAL HISTORY

The patient has never been seriously ill. Psychiatric diagnosis is passive-aggressive personality.

The patient has been detoxified 11 times: 5 time medically in hospitals (3 times at Metropolitan Hospital, WMA; 2 times at Manhattan General Hospital, WMA); twice in the streets with tranquilizers under medical supervision, and 4 times cold turkey at his girl friend's house. The patient attempted detoxifications 2 other times through a private physician with dolophine, but never completed the detoxification as he began using the dolophine as a booster with his heroin. The patient abstained once for 6 months; once for 3 months; twice for 2 months; once for 6 weeks; once for 1 month; and 5 times he returned to drugs his first day after kicking.

NARRATIVE

PHASE I (TO AGE 17)

Family. The patient comes from an intact family—five brothers and one sister. He is the elder of a pair of twin brothers. Two brothers died in childhood, age 9 months and 18 months. Two brothers died in adulthood, age 23 (stabbed in a bar) and age 32 (wood alcohol poisoning). Twin brother started using drugs at age 24. The patient's father began drinking heavily when he began working for the Works Progress Administration (WPA), after being fired from a carpenter's job he had held for 11 years.

The family lived in a large six-room apartment on 104th Street in Harlem, in what was then a well-kept neighborhood. The family did many things together, both religious and social activities. The three brothers went together to dances, ice-skating, etc. All of the holidays were celebrated at home. The children in the neighborhood were invited to all of the holiday festivities. To the patient's knowledge, his parents were a model couple.

School. The patient graduated from textile high school. He considered himself to be somewhat above average as a student. He did not study much, and this caused him some difficulty at home since school was such an important factor in the household. "I got by on what I heard in class."

Work. During this period in his life, the patient did not work. He did not want to and did not feel that he had to, although this was in the midst of the depression era. He remembers that his father, a cabinet maker, was a good provider.

Friends. The patient had many friends, both male and female. He was very active with them. He went out with many girls, although he never went steady. The patient felt that he was a "ladies man." His first sexual experience was at age 15 with a married woman who was age 22. The patient fostered and maintained friendly relationships with his peers in the neighborhood, and every Saturday he would teach the neighborhood boys athletics in the park.

Leisure Activities. At age 15 he became a charter member in a New York Social Club. He eventually became its president. The club has helped three members who stopped using drugs, and the club members have also tried to help the patient. He was actively involved socially in the neighborhood, particularly in sports. He participated in swimming activities at the local YMCA. He was also very actively involved in church social activities. The patient's social life was full, active, and enjoyable.

Use of Community Resources. Church and YMCA.

Illegal Behavior. The patient was not involved in any illegal behavior during this phase.

Addict Involvement. None.

Support of Substance Use. The patient used no substances during this phase and had no habit to support.

Summary. The patient's behavior during this phase can be described as highly conventional. He was not involved in illegal or narcotic centered behavior.

PHASE II (AGE 17–29)

Family (primary). The family remained close-knit, and the patient continued living with his family up to age 21 when he married. His twin brother, who also lived at home, started using drugs at age 24. The family learned of the brother's drug use when he was 25 and he was arrested. The brother has been using drugs ever since. The family was upset by their son's drug use and arrest, but did not seem to get involved in their son's rehabilitation. At age 22 the patient became aware of the fact that relationships in the family—particularly between his father and mother, were not as good as he had previously perceived them to be. He had made very little of the fact that his father believed quite strongly and spoke quite often of Mayor LaGuardia and Marc Antonio being against him. He came home one day to find his father attempting to stab his mother. The patient intervened, took the knife away, and drove his father to Bellevue Hospital. This incident proved to the patient that "they must have had altercations before, but we never knew about it." The twin brother was discharged from the Army in 1946 on psychiatric grounds and was committed to Montrose VA Hospital, from which he escaped a number of times. (The patient committed his brother to Bellevue Hospital 1 week prior to his own hospitalization during which this history was taken.) When the patient was age 23 a brother was stabbed to death in a bar in what the patient described as being a case of mistaken identity.

Family (conjugal). At age 21 the patient married a Puerto Rican girl. His family and friends considered them a model couple. The patient was 24 when his first child, a son, was born. The patient described his wife then and now as a very submissive woman. The patient sees her as a person who "never lets her emotions out. I never know what she's going to do until she does it."

School. Upon being graduated from high school in the midst of the depression, the patient went to an NYA carpentry school for 18 months. Soon after finishing carpentry school, he joined the Merchant Marine. Through the union, he went to school for 6 weeks to learn to be an able-bodied seaman.

Work. Although the patient had been graduated from a vocational high school and was qualified and sufficiently skilled to seek employment, he went on to further training in another skill. The patient's first work experience was in the Merchant Marine which he joined at age 21, and in which he remained for 7 years. His verbalized motivation for joining the Merchant Marine was that he wanted to avoid being drafted into the Army. He shipped out on his first trip one week prior to getting his draft notice. During the 7-year interval in the Merchant Marine the patient was never unemployed. He never took more than the 30-day shore leave allotted to him after a trip. A number of times he was involved in long trips such as the 14-month trip he made immediately after his son's birth.

Upon leaving the Merchant Marine at age 26 he began working as a silk screener. He worked at this until age 30. He started at $65 a week, was raised to $95, and when the foreman of the factory went into business himself, the patient became his foreman. He was steadily employed, often working on Saturdays and holidays for which he was paid off the books. He left the job because he didn't like working around the clock or on Saturdays or holidays.

Friends. The patient had many friends both male and female, and he was very active with them. He continued going out with girls from the start of his marriage on. He felt that while his marriage was a perfect one, he was a ladies man.

Leisure Activities. The patient's employment in the Merchant Marine prevented him from having much free time. The time he did have, however, he thoroughly enjoyed. He considers his social life to have been a full one in which he went to parties often, went to beaches, dances, and also actively participated in sports. While in the Merchant Marine, he became quite active in the union, and maintained his activities in the social club and in the church. He continued his weekend athletics in the park, now taking his son and his son's friends to the park every Saturday morning to play ball.

Use of Community Resources. Carpentry school, part of National Youth Administration (NYA); Merchant Marine union school; savings bank; State hospitals for father; and V.A. Hospital for twin brother.

Illegal Behavior. The patient was not involved in what can be termed illegal behavior. During this phase, however, he began his heavy gambling (age 20), at which he could sit at a card table for three days round the clock.

Addict Involvement. None. The patient had no friendships or acquaintance with narcotics addicts.

Support of Substance Use. The patient had no narcotic habit to support. He supported his alcohol use through salary and gambling.

Summary. Excepting his extra-marital relationships, the patient's behavior for this phase can best be categorized as high in conventional behavior, and no involvement in illegal or narcotic centered behavior.

PHASE III (AGE 29–32)

Family (primary). The family continued to be very close. The patient saw his mother almost every day, his brother and sister very often, and visited his father in the hospital every 2 weeks. The patient's father died in the hospital of a heart attack.

Family (conjugal). The patient considered his marriage to be a model one. At age 30 he began going steady with his present girl friend and has continued to do so for the past 11 years. She acknowledges him as her husband, he feels the same, they have a joint bank account, joint apartment, and his out-of-wedlock daughter bears his name. His wife did not know about this relationship. He used his gambling as an excuse to stay out at night. His girl friend knew that he was married.

School. The patient did not attend school during this phase.

Work. The patient continued to work as a silk screener for 1 year and then took a job as an officer at the Triborough Bridge and Tunnel Authority and worked at this steadily for 11 months, and then applied for a job at Hunter College. He worked there for 3 months and left primarily because half of his time every night was spent in "porter work." During this time he had applied for a job with the Police Department as a chauffeur in their department of supplies.

Friends. The patient still had many friends to whom he felt close and with whom he was active. He saw his friends quite frequently during the week. During this period of his life, while maintaining "two marital relationships," he nevertheless stated, "if anybody came my way I never passed them by."

Leisure Activities. The patient had more free time than when he had worked in the Merchant Marine and enjoyed it. He would often go to his club and listen to records, drink, and go out with girls. His social life consisted of parties, going to the beach, dances, and gambling.

Use of Community Resources. Savings bank.

Illegal Behavior. The patient was not involved in illegal behavior during this phase except for his extra-marital relationship.

Addict Involvement. The patient kept a jar of marijuana in his kitchen cupboard and nonnarcotic using friends of his would come by a few times during the week and they would smoke socially. He rolled his own. His wife was never actively involved in this.

Support of Substance Use. The patient supported his marijuana use and social drinking through his salary and gambling.

Summary. The patient's behavior during this phase can be categorized as high in conventional behavior, low in illegal behavior, and low in narcotic centered behavior.

PHASE IV (AGE 32–37)

Family (primary). The patient's family relationships remained close. He visited his mother five or six times a week, would see his brother three or four times a week, and would likewise see his sister often. Upon his father's death, his mother began to work as a housekeeper. The patient's other brother died at the beginning of this phase.

Family (conjugal). The patient considered his marriage to be fine. He spent a lot of time at home but "ducked out one or two evenings a week to see my girl." He would come home at 10 o'clock in the morning and his wife would never comment about it. Instead, she would make breakfast for him as if he were returning from work. This tended to make him feel guilty about his extra-marital relationship.

School. At age 32 the patient went to Notary Public school for 5 weeks in order to be licensed as a Notary Public. During this same period, he began informally to study to get licensed as a real estate salesman.

Work. At age 32 the patient began working for the Police Department as a chauffeur in their department of supplies. Two years after being employed by them, the patient became a partner in an auto school, was an instructor for the auto school, became a Notary Public, and became a real estate salesman. The patient was evidently a competent driver for the Police Department and managed to finish a day's work by 2 p.m. They were so pleased with his work that they signed him out as of 4 p.m. Since he was able to finish his work with the Police Department by 2 p.m., afternoons and evenings were spent in his other business ventures.

Friends. His relationships with his friends continued to be satisfactory. He would see them very frequently and engaged in numerous conventional activities with them.

Leisure Activities. His social life continued to consist of dances, parties, beach parties, boat rides, skating, and playing ball.

Use of Community Resources. Savings bank; Notary Public school.

Illegal Behavior. The patient's illegal behavior continued to consist solely of his extramarital relationship.

Addict Involvement. The patient had no close friends who were addicts. He continued to smoke marijuana socially with his friends.

Support of Substance Use. The patient supported his marijuana use and social drinking through his salary and occasional gambling.

Summary. The patient's life during this phase was again high in conventional behavior and low in illegal and narcotic centered behavior.

PHASE V (AGE 37–40)

Family (primary). The patient's relationship to his family remained close. He continued to see his mother frequently, and she was willing to help him by getting him into a hospital when he was addicted. When the patient was hospitalized his mother helped his wife financially. The patient saw his mother regularly when using drugs. The patient saw his twin brother frequently when he was home. He saw his sister regularly. He feels that she is another source of potential help for him if and when he would need it.

Family (conjugal). During the second year of his habit, his wife found out that he was using drugs. She would help him get into hospitals and help him when he got out. He feels that his wife, like his sister, saw his drug habit as something that he could "turn off and on like a faucet." During the first few years of drug use, the patient concurred with his wife on this.

School. The patient did not attend school during this phase.

Work. The patient remained with the Police Department for this phase of his drug use. For this 3-year period he used drugs while being employed. "I never get high or nod. Heroin takes away any tiredness, pains and aches that I feel. It facilitates my work. I work better and feel better. It helps me with my feelings; I want so much, have so much potential, but feel I couldn't achieve." During the same period, he sold his share of the auto school to his partner (up to this time he had planned to buy his partner out), lost his real estate salesman license, but retained his Notary Public license. For the first 2 years of drug use the patient was able to save money from his salary.

Friends. Most of the patient's friends were not addicts. He continued seeing them two or three times a week, although he tried to stay away from them when he was strung out. "They seek me out to help me." He felt that his friends were still in his corner and this seemed to upset him. The patient continued going with his girl friend as well as numerous other girls. He felt that with his use of drugs his relationship with his girl friend had become more intense. The patient stated that his girl friend showed more of a desire to help him than his own wife. The four times the patient kicked in the streets during this phase were with his girl friend's help.

Leisure Activities. He had begun during this phase to dichotomize his social life, i.e., parties and dances with his girl friend, movies with his wife. The patient continued to belong to the Social Club, although when strung out he did not frequent the club. When not strung out, he went to the club approximately three times a week for the weekly meeting, for sports, dances, and card playing. With the beginning of his drug usage, he no longer involved himself in church activities. During this period of his life the patient went to PTA meetings at both schools (son's and daughter's) since he manifests an avid interest in their development.

Use of Community Resources. Savings bank; psychiatric hospitals for his twin brother's care, and PTA.

Illegal Behavior. For the first 2 years of drug usage, the patient's habit was supported primarily through work. As indicated previously, he was even able to save money. At age 39 the patient became involved in criminal activities to support his habit. This entailed passing phoney checks, using stolen credit cards, passing money orders, and passing prescriptions. The patient describes these activities as the sum total of his illegal behavior.

Addict Involvement. The patient did not mention friendships with addicts. He would see them daily to cop and then leave.

Support of Substance Use. While using heroin as his primary drug the patient began using doriden, dolophine and morphine. He smoked marijuana infrequently, drank socially, and gambled infrequently. The patient supported his habit through work and his criminal activities.

Summary. With the beginning of narcotics usage and multiple addiction, the patient's behavior can be categorized as continuing to be high in conventional behavior, low to moderate in illegal behavior, and low in narcotic centered behavior.

PHASE VI (AGE 40–)

Family (primary). The patient and his mother still maintained a close relationship. His mother continued to be willing to help him by helping him get into a hospital when he was addicted and by helping his wife financially. The patient continues to see his mother on a regular basis. The patient's relationship with his sister has not changed significantly. Although his sister does not consider his drug usage to be symptomatic of an illness, but rather feels that he is using drugs because he wants to, she nevertheless tries to help him. He continues to see his addicted twin brother; when his brother was a patient at Montrose VA Hospital, the patient was a nurse's aide there and helped him whenever possible. Prior to the patient's own present admission to Metropolitan Hospital, he committed his brother to Bellevue Hospital.

Family (conjugal). The patient's relationship with his wife in the last year can be characterized as being less close. The patient feels that his wife continues to fulfill the duties of a wife, notwithstanding the fact that she found out about his extra-marital relationship. His wife has never said a word about this. In the last year there has also been an increase in the distance between the patient and his teenage son. Much of this appears to be due to the fact that although his addiction has not been discussed with his son, the patient is sure that his son is aware of the meaning of his hospitalizations. The patient feels extremely guilty about this.

School. Upon discharge from Manhattan General Hospital the patient applied for a job as a nurse's aide at Montrose VA Hospital. The first few months at Montrose VA Hospital were spent at a nurse's aide school. The patient was not using drugs at the time.

Work. After finishing his nurse's aide training, the patient worked for the following 11 months as a nurse's aide. He worked regularly at this job and would snort once every 2 or 3 months. The patient returned to New York City for the Christmas holidays after a year of almost complete abstinence. He became addicted to drugs again, returned to Montrose VA Hospital and resigned. He then returned to New York and within a month he returned to work for the Police Department. He had a car accident after 3 months of work.

The patient had resigned from the VA hospital rather than returning there to work in order to guarantee his use of the hospital as a future reference, or else to be able to return to work there in the future. During this phase of the patient's life, although he "resigned" from the Police Department, he has returned twice for 1 day's work each year in order to qualify for remaining on their list. During this same interval, the patient has done odd jobs for various landlords in the neighborhood where his girl friend has an apartment. He has had numerous offers for permanent work from these landlords but has refused, feeling that he is a skilled craftsman and that such a job would be too demeaning. The patient has generally used drugs while working.

Friends. There has been no change in his relationships with either male or female friends during this phase. All of his friends continue to be nonaddicts and he continues to avoid them when strung out, while they continue to seek him out in order to help him.

Leisure Activities. The patient continues to belong to the Social Club, going there a few times a week when he is not strung out. He continues to be involved, although minimally, in the PTA. His social life continues to consist of parties and dances with his girl friend, and movies with his wife. His drug involvement has not significantly reduced his social life. His feeling is, "Once I know I have enough for my needs, I can have all the social life I want."

Use of Community Resources: Psychiatric hospitals for his twin brother's care; PTA, and Nurse's Aide School.

Illegal Behavir. The patient has continued the same illegal activities as in his previous addicted phase (passing phoney checks, using credit cards, passing money orders, and passing prescriptions).

Addict Involvement. The patient continues to be minimally involved with other addicts. He sees them daily, but just to cop.

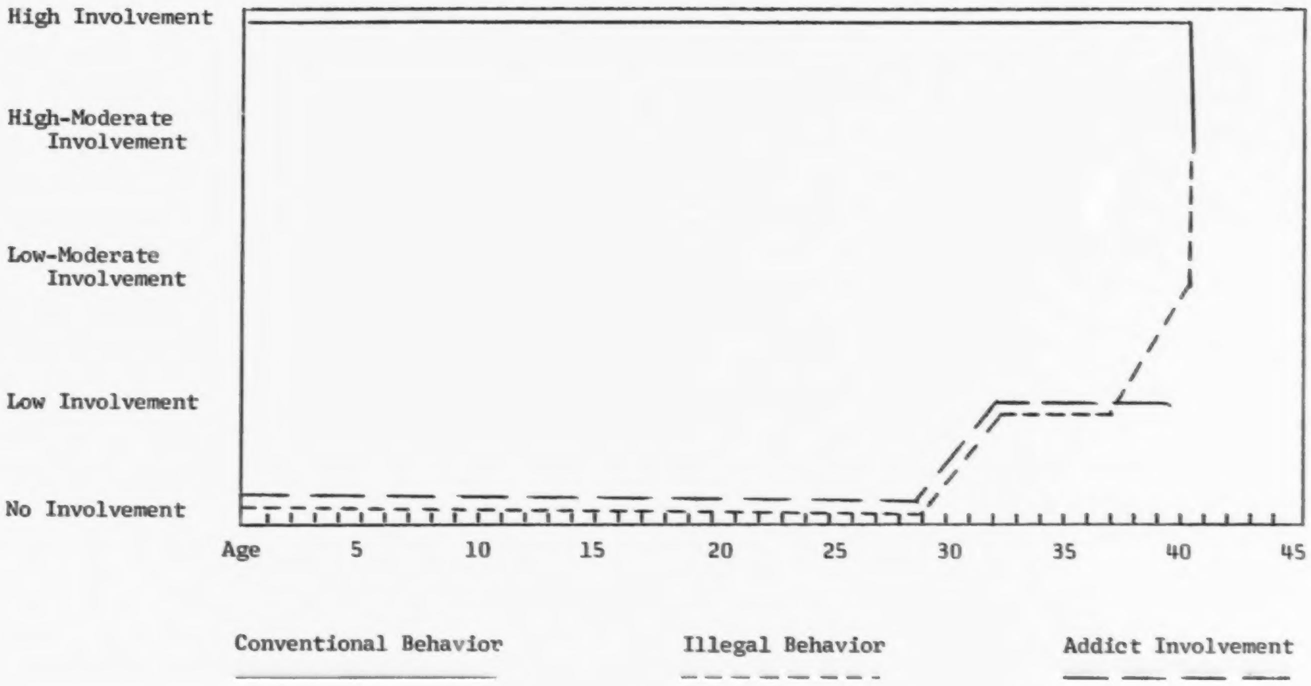
Support of Substance Use. While heroin remains the patient's primary drug, he continued to use doriden and morphine, and began using demerol, dilaudid, tuinal and seconal. He drank socially, smoked marijuana infrequently, and gambled rarely. The patient supports his habits through work and his criminal activities.

Summary. The patient's behavior during this phase can be categorized as moderate to high in conventional behavior, moderate to high in illegal behavior, and low in narcotic centered behavior.

SUMMATION

This patient's life style adaptation can be seen as a relatively constant high degree of involvement in conventional areas of life prior to and subsequent to drug use; as a consistent increase in involvement in illegal activities as the patient proceeded from no involvement, prior to drug use, to moderate to high involvement in illegal activities as he began using a variety of drugs in conjunction with heroin (since age 40); as a consistent minimal involvement with other addicts subsequent to his use of drugs, with no involvement with them prior to his use of drugs.

CASE HISTORY D



Family (primary). The patient has maintained a close and involved relationship with the members of his family throughout his whole life; drugs have neither inhibited nor facilitated these relations.

Family (conjugal). Notwithstanding the patient's active extra-marital relationship, up to age 40, when his wife discovered this relationship, the patient felt that his marriage was a model marriage; he felt close to his wife. As he has become more involved in drug use, he has relied more and more on his girl friend for emotional support. The patient's wife, mother, and girl friend have consistently supported him.

School. The patient's desire to better himself has remained an ever present motivating force both prior to and subsequent to his use of drugs. Whenever he felt schooling was necessary to better himself, he went to school; drug use did not inhibit this.

Work. The patient has always been exceptionally involved in the area of work, at times having numerous jobs simultaneously. In the last 2 years, as he has begun to use a variety of drugs in addition to heroin, while he has not worked daily he has nevertheless continued to work fairly regularly.

Friends. Both prior to and subsequent to his use of drugs the patient has maintained an active interpersonal and heterosexual life. While his friends have been substance users (e.g., alcohol and marijuana), they have never been narcotic addicts. As he has become more involved in drug use he has seen his friends less frequently because he did not want to be around them when he was high or strung out. His friends, however, have consistently sought him out and accepted him, whether or not he was using drugs.

Leisure Activities. The patient has continued to be actively involved in numerous leisure time activities throughout his life. When using drugs, he has always seen to it that he has a sufficient supply of drugs so that he could actively engage in leisure time activities. The one major change that has occurred during the last four years is that he has dichotomized his leisure time activities, so that he does certain things with his wife and certain other things with his girl friend.

Illegal Behavior. Prior to his use of drugs, and subsequent to his use of marijuana only, he was never involved in illegal activities. Subsequent to his use of narcotics and barbiturates he has become increasingly more involved in illegal activities.

Addict Involvement. Prior to his use of drugs the patient was unacquainted with narcotic addicts, other than his twin brother. Subsequent to his use of marijuana (age 29) which he smoked socially at home with friends, and other drugs (age 37), he began to know other addicts, but spent a minimal amount of time with them and never considered any addicts to be friends of his.

Support of Substance Use. Subsequent to his use of alcohol and marijuana, he supported the use of these substances through his saltry and his gambling activities. Subsequent to his use of narcotics and a variety of other drugs he began to depend less on his salary and more on illegal activities to support these habits.

CASE HISTORY E

Mrs. G is a 34-year-old woman of Irish parentage. She is 5 feet 6 inches tall with straight brown hair and brown eyes; she usually dresses in a loose, flowered cotton dress and oxfords with white socks. Mrs. G's parents died when she was 4 and she spent the next 11 years in institutions. At the age of 15, she started working as a live-in maid. At 17 she married, and both she and her husband worked as janitors. Mr. G had a heart condition, and for the last few years of his life was bedridden. He died 6 months after the birth of their last child. Mrs. G has said that she began drinking heavily during the last year of his illness, when the pressures of working and caring for him and the children became too much for her. She was unable to continue working after his death, and applied for public assistance.

Mrs. G was referred to the Division's program 2 years ago by the Department of Welfare. The family situation, as presented by them, involved Mrs. G and her six children, then aged 14, 11, 10, 7, 6, and 3. Mrs. G's neighbor had made a complaint to the Society for Prevention of Cruelty to Children, on the grounds that Mrs. G drank, did not keep the house in good condition, and was incapable of taking care of the children adequately. Based on their evaluation, the SPCC was prepared to take the case to court to have Mrs. G's children removed from the home.

In our evaluation of the family, we felt that improved living conditions (the family was living in three rooms), and educational counseling of Mrs. G could improve the situation. Involved would be rehousing and homemaker service by the Department of Welfare, assistance from the guidance counselor in the school attended by all the children, and medical services from the clinic in the neighborhood.

Just after our initial evaluation, the house in which the G family lived burned, and they were rehoused by the Department of Welfare in a six-room apartment. Welfare hesitated to give Mrs. G the money for furniture because they felt she would misuse it. It was agreed that a worker from our staff would meet Mrs. G at the Welfare Center, get the money, and go shopping with her. Mrs. G expressed satisfaction at this arrangement, and the shopping trip to furnish the new apartment turned out well.

Welfare also arranged for a trained homemaker to go to the G home two mornings a week to help Mrs. G learn how to care more satisfactorily for the house and children and to enable her to attend sessions at our Division. Mrs. G enrolled her youngest child in Operation Headstart at the local public school, and the older boys joined a Cadet Corps in the neighborhood. Mrs. G joined the Parents' Association and became involved in their various activities.

During her 2 years of work with us, Mrs. G expressed concern over her eldest son. In the past he had been involved in sniffing glue and she suspected that he had also used heroin. He now drinks a good deal and occasionally uses barbiturates, although he has never been in trouble with the law for this. At the age of 16, he dropped out of the school and refused to look for work. This endangered the family's eligibility with the Department of Welfare.

One night, while intoxicated, he was picked up by the police as he was riding in a stolen car and charged with resisting arrest and possession of a weapon (a knife he kept in his pocket). Contact was made with the Legal Aid Society, and an appointment was made to discuss his case before the trial. He was given youthful offender treatment and placed on probation. However, he did not cooperate with his probation officer, who considered returning the case to court for resentencing. As an immediate alternative to this, a joint case conference was planned to include all the agencies involved with the family, i.e., our Division, the Department of Welfare, Board of Education Guidance Department, and the Office of Probation. In addition, a representative of the New York State Division for Youth was present.

The evaluation which was presented to this conference included some items related to his drug use. His history of drug and alcohol use showed this behavior to be consistently related to peer group activity. Although he did not belong to a formal gang, he did have an extensive and close-knit group of friends; substance use seemed to be reflected throughout the group. He progressed from sniffing glue to snorting heroin, but went no further with heroin use. He continues to smoke marijuana occasionally, and uses pills when some of his friends have them available. He shows no evidence of a consuming interest in these substances, but uses them if they are offered. His drinking, which has caused him to get into legal difficulties, is group-related and often associated with other delinquent activities which he goes along with, but rarely initiates.

A discussion of factors associated with this delinquent behavior, together with consideration of his lack of involvement in conventional activities and satisfying family life, led to the recommendation that this boy be placed in a residence program where he might benefit from the structured environment and receive vocational training. At the same time, more intensive work would be undertaken with the younger children so that they might learn other more satisfying and less dangerous activities and avenues of expression as they enter adolescence.

Throughout this difficulty with her eldest son, although she still feels incapable of dealing with his particular problem, Mrs. G has been able to maintain her home and give excellent care to her other children.

CASE HISTORY F

A private school in New York City contacted the Division to discuss the preparation of a curriculum about narcotic addiction for its student body. The school serves first through 12th grades, and includes children of middle, upper-middle and upper class families in Manhattan. It is situated between a high income area and a low-income area of the borough; the students generally have access to both money and drugs.

The philosophy of the school has been developed with a view toward the broadest educational content possible and toward freedom of both curriculum development and exploration. The faculty consists of a basic group of core teachers who are primary to the transmission of knowledge and the building of student-faculty relationships. Complementing the core staff is a group of specialists in the arts and humanities, and physical and biological sciences. Specialists are available to core teachers and students alike for special areas of interest as they evolve out of the basic core curriculum.

The request for the "addiction curriculum" came from the director of the school at the request of two core teachers and one specialist, who believed that they had evidence of marijuana use among a group of ninth-graders. One student had come to the core teacher to express anxiety and concern about the possibility of full-blown addiction evolving out of his "pot-blowing." In further discussion, the teacher found that knowledge about drug use was common to the entire student body, but the phenomenon was not a familiar one to the faculty. On a second occasion, a student had spoken of "the man in the white raincoat and sunglasses" who frequented the local luncheonette, did nothing, but was suspected of pushing. A request was made to the school director, and he agreed to permit our staff to speak with two classes about drug addiction, one ninth grade class and one eighth grade class, twenty students per class.

A team of three staff persons visited the classes—one to lead discussions, two to observe. The agenda was developed in a form to elicit a discussion response from the class and to allow an opportunity, on a superficial level, to evaluate prevalence of use among class members. Agenda items included pharmacology and terminology of drugs and juvenile patterns of use. Estimates of substance use were based on knowledge of drugs, use of language, knowledge of drug effects, traffic, prices, and patterns of use. In the ninth grade class, it was estimated that 70 percent of the class were using marijuana, in the eighth grade, about 40 percent.

On the basis of these discussions and estimates, a meeting was held with the school director and faculty members, and it was suggested that a series of seminars be held with key core, specialist, and administrative staff to develop an understanding of juvenile drug use. Clearly, an "addiction curriculum" directed to students was not called for at this time. In the first place, both theoretical and first-hand knowledge about drug use already existed among the student body which was far more extensive than that which existed among faculty. Secondly, it was felt that in terms of primary prevention, it was necessary to have those who would teach equipped to deal with problems which would undoubtedly be encountered in the process of teaching.

Therefore, the staff seminars were developed to better prepare the faculty having a primary relationship to the students to approach student problems, specifically drug use, on a comprehensive level. Effort was made to familiarize staff with the community aspects of drug use so that action might be aimed realistically at levels of the phenomenon other than the drug use itself, i.e., family and peer relationships, leisure time activities, school planning for extracurricular involvement and student counseling, and a program to interest parents in an action role related to legislative policy change.

As the initial step, an "addiction curriculum" was thus directed toward the staff who were concerned for their students, rather than at the students themselves. It was felt that the staff who were in consistently close contact with students were in the crucial position to intervene where intervention was called for, and could themselves determine this and act effectively given community mental health training, consultation, and support.

CASE HISTORY G

A number of referrals were made to the State Division of Vocational Rehabilitation from our program for the purpose of helping patients reach improved levels of functioning in employment. In each instance, it was clear that the criteria of the Division of Vocational Rehabilitation required that the patient be diagnosed as physically or psychiatrically disabled before assistance could be given. In other words, if a drug user had no major physical or psychiatic pathology, there was little hope for acceptance into a testing, training or retraining program.

On the basis of case materials of those referred, our staff engaged the administrative personnel of the Division of Vocational Rehabilitation in a series of discussions which documented the obstacles to rehabilitation represented by their own policies. We took the position that, given the current situation, drug dependence was a chronic condition, disabling to the individual in relationships with family, employers, friends, and caretaking institutions. We termed this condition a "social disability" and suggested to the Division of Vocational Rehabilitation that they consider including such a category in their criteria.

At the suggestion of the Administrative Director, it was agreed that a series of seminars be developed, the content of which would be aimed at a policy change which would incorporate such types of disability in the criteria. The target personnel selected in the Division of Vocational Rehabilitation were the local District Director, the Special Services Director, the Social Service Director, the heads of the Testing, Training, and Retraining Sections, and representatives from the State Office of Vocational Rehabilitation.

Content materials for the seminars include the documented cases of our Division, with evaluation of patterns of behavior based on tabulations from research conducted with our total population of referrals.

The role of the Division of Vocational Rehabilitation staff in the seminars was seen as that of a transmittor of knowledge about the present and future function of their division in this area to other agencies. The role of our staff was that of transmittor of knowledge about (1) the impact of substance dependence upon the community; (2) obstacles to treatment and rehabilitation as found in governmental policies and procedures; and (3) appropriate targets for change in this situation.

The joining of these two groups in an effort directed toward policy and procedural change represents a fusion of voluntary and public knowledge and experience, with the ultimate objective of secondary prevention of substance dependence and the alleviation of problems encountered in rehabilitation.

CASE HISTORY H

The nature of the interrelationships among dominant community attitudes, stigmatic public policies, deviant subculture norms, and the deviant's self-image are clearly suggested by data pertaining to drug and alcohol use. Realizing this, the role of the change agent and the roles of the hospital or other caretaking and custodial institutions in the phenomenon must be taken into account. This is particularly true since (1) the community tends to delegate responsibility inordinately and inappropriately to enforcement, correctional, and custodial agencies; (2) social planning is inadequate; (3) there is a paucity of preventive services; (4) scarce resources and personnel are typical; and (5) there is a tendency among professionals as well as among public officials to respond to community attitudes and political pressures which force undue attention on the unacceptable behavior of the deviant to the exclusion of effective concern with the social and cultural context provided by the community.

It is therefore appropriate to define professional and agency personnel as primary intervention targets. A case history of intervention in such a case would be a description of a procedure for working with and training individuals at the organizational level. The case which follows is an outline of one of a series of Training Institutes initiated for this purpose.

The period of preparation for the Institutes involved a series of activities aimed at the selection of content materials and consultants. Personal interviews were held with seventeen administrative and supervisory professionals functioning in public and private alcohol and narcotics programs to elicit pertinent materials for training. From this group of personnel, five were selected as consultants who would participate in the panel discussions of the Institute to present their views and programs related to alcohol and narcotics use. A review of the literature in a variety of fields, including alcohol, narcotics, mental health, sociology, psychology, psychiatry, social work, community organization and public health, provided suggestions for the development of specific curriculum materials for use in training. An Institute Kit was assembled containing theoretical, clinical and research materials pertinent to training.

In each Institute, there was an effort to select participants from those cities which would offer a variety of experience with addictions for purposes of cross-fertilization in training. Seven participants were involved in the Institute outlined here. They included: two Borough Directors of the New York City Youth Board; one Research Director of the Lane County Youth Project, Eugene, Oreg.; one Research Director, Community Progress, Inc., New Haven, Conn.; one Assistant Narcotics Coordinator, New York City Department of Health; one Director, Inservice Training, Malcolm Bliss Mental Health Center, St. Louis, Mo.; and one Area Director, Neighborhood Conservation Bureau, New York City.

Of these participants four were involved in research and/or action programs aimed at deviant youth; one was an administrator of a major city public health program aimed at narcotics users; one was in a large private hospital alcohol program as an administrator and, more recently, Director of Inservice Training; and one was an administrator of a city conservation program involved in upgrading housing, health and sanitation standards in several deteriorating neighborhoods of the city.

The combination of research and action personnel in the same group is valuable. Research personnel tend to strive for application of theoretical formulations to practitioner's experience, and action-oriented personnel tend to apply their specific experience to the formulation of more generic areas of consideration. Participants have commented on the need to overcome the limitations of tradition bound professional disciplines in creatively approaching problems of social deviation such as alcohol and drug dependence.

The format for the Institute was as follows:

I. FIRST DAY

9:00–9:30 a.m. *Introduction*

9:30–11:45 a.m. *Consultants' Panel*

An exploration of views of leading professionals and programs in the fields of narcotics and alcohol.

1:00–2:30 p.m. *Evaluation of Panel Discussion by Participants*

Discussion of content of morning panel and evaluation of areas for further exploration.

2:30–4:30 p.m. *Introduction of Community Mental Health Approach to Addictions*

Applicability of community mental health approach to addictions as related to material and content of previous discussions; review of pertinent conceptual constructs in mental health and addictions.

II. SECOND DAY

9:30–10:00 a.m. *Introduction to Research Aspects*

10:00–12:00 Noon *Research Design and Instruments*

1) *The Screening Instrument and Interview*
2) *The Case Study Instrument and Interview*

Introduction of general research design in narcotics and alcohol, with two specific areas interpreted by a sociologist and a clinical psychologist. Discussion of design and instruments as they are developed in the session.

1:30–3:30 p.m. *Review of Research Materials, Coding, Analysis, Findings.*

Continued discussion of the various aspects of research; potential use of instruments in local communities.

3:30–4:30 p.m. *Interrelationships of Research and Action*

A discussion of the values and problems inherent in the research-action addiction program of the sponsoring organization; applicability to local communities.

III. THIRD DAY

9:30–12:00 Noon *Case Conference.* Participants: psychiatrist, public health nurse, caseworker, sociologist.

A full staff case conference, discussion screening interviews of patients ready for evaluation and disposition. Training participants will join with staff in discussion.

1:00–3:00 p.m. *Implications of Institute Content for Local Communities.*

Discussion of content of Institute and relationship to communities and programs of participants; specific reference to community planning and organization.

3:00–3:30 p.m. *Plans for Postinstitute Visits*

Discussion of visits by sponsoring organization staff to local communities during following month.

The Training Institute format realizes the objectives of logical, systematic dissemination of knowledge and understanding of the community mental health view of addictions as one form of social deviation. The content of the Institute—related to the nature of the problems of substance use, patterns and phases of use, patterns of behavior of users and caretakers, systematic classification of problem users and implications thereof, establishment of action goals and relatedness to local community problems—has proven to be stimulating, exciting, and transmittable. Training participants have commented on the fact that the content of the Institute was suitable, appropriate, and most applicable to social problems which they faced in their local communities.

Evaluation questionnaires involve a variety of aspects of the Institute, including general assessment, usefulness and applicability of content, specific assessment of alcohol and narcotics content, training format and methods, and training staff.

The short-term effects of the training programs are evaluated in four ways; relevant attitudes of participants before and after the training are measured (through personal conferences between participants and the training officer before and after the training session, and through administration of questionnaires on knowledge and attitudes about substance use); change in the administrative and service behavior of the agencies represented at the Institute is assessed (through survey instruments covering such indices of change as modification of bylaws, extending or retrenching of services, pooling of funds, or establishment of cooperative procedures and projects between agencies); the curriculum materials developed for the training are reviewed for relevance and effectiveness (the present Manual is an example of this curriculum material); and the methods of training used in transmitting the program content are examined. Evaluation of each of these areas is undertaken both by the participants through self-evaluation and by research personnel from the sponsoring organization.

Institute participants, and especially those concerned with problems in community organization and social planning, are generally quick to respond to discussion of programming in the addictions by voicing their recognition of problems familiar and meaningful to them in their own specialized activities. There is indication that these discussions provoke effective new insights in their own fields.

APPENDIX D

A RESEARCH STUDY

This will be a somewhat more detailed consideration of the research study described in chapter III. The purpose is to present a procedure for gathering and analyzing data in a wide range of areas related to the phenomenon of drug dependence.

The method of choosing individuals for inclusion in our sample of patients entering the Metropolitan Hospital narcotic detoxification service has been described. Information was obtained from these 253 patients in 3 phases: just prior to or upon admission, during hospitalization, and after discharge. This information was then used to construct a picture of how different kinds of drug-dependent individuals live, how drug use is related to this, why they come to the hospital and why they leave, and what they do after they leave.

ESTABLISHMENT OF TYPOLOGY

One of the major objectives of the study was to establish whether or not there are, in fact, "different kinds of drug dependent individuals," reflecting different modes of adaptation to the community environment, that is, life style adapatation. The life style adaptation typology was a two-dimensional one involving the variables of conventionality and criminality, as discussed in this manual. This is how an individual was placed in one of the four life style adaptation categories (it should be borne in mind that this typology applies to the individual's life at the time of his contact with the hospital; life style adaptation is dynamic and can change over time, as is illustrated by case histories A through D in appendix C):

Indexes of conventionality and criminality, with high-low distinctions, were constructed as follows:

Conventionality

1. Work conventionality
   - a. high (42 percent)—either worked steadily or at longest or best job, or at a job while using drugs during 3 or 4 months previous to date of interview.
   - b. low (58 percent)—worked in none of the above circumstances.
2. Family conventionality
   - a. high (58 percent)—close with family, and either got along with or talked to all family members, or wanted to be like someone in the family.
   - b. low (42 percent)—all others.
3. Friends conventionality
   - a. high (51 percent)—engaged in conventional activities, involving more than isolated or solo activities, with at least two persons seen most or best friends.
   - b. low (49 percent)—engaged in such activities with fewer than two such persons or friends.
4. General conventionality: leisure-time activities (number of specific activities reportedly engaged in during the previous three or four months of nine activities asked about, e.g., read a book, dinner in a good restaurant, etc.)
   - a. high (47 percent)—6 to 9 activities.
   - b. low (53 percent)—0 to 5 activities.
5. General conventionality: normal life activities.
   - a. high (51 percent)—engaged in conventional activities re: family, work, involving more than just isolated or solo activities within last 2 months.
   - b. low (49 percent)—did not engage in these activities.

Criminality

1. Recent criminal acts (incidence of criminal-type acts recently engaged in).
   - a. high (55 percent)—minimum of at least one criminal activity depending upon a network (or two or more nonnetwork activities).

b. low (45 percent)—maximum of two criminal activities independent of a criminal network.

2. Criminal-social relationships (a composite of the scores for the number of friends or persons whose present or usual occupation is criminal and those with whom the patient engaged in joint criminal activity).
   a. high (55 percent)—minimum of at least one friend with criminal occupation or one criminal partner.
   b. low (45 percent)—no score on criminal relations.

First the entire sample was divided into four groups using the most stringent criteria possible to distinguish between high and low overall conventionality and high and low overall criminality, by requiring an individual to score zero on the criminality index—thus indicating an absence of recent criminal acts and criminal-social relationships—in order to be classified as low in criminality; and by requiring him to score five on the conventionality index—indicating a high score on each of the five subindexes of conventionality—to be classified as high on conventionality.

The results of applying such severe cutting points between high and low values of the two adaptational dimensions are shown below in table A (in this and the following tables, the basic N will be either 253 or 170 [a subsample] with variations due to a few "no answers" or the timing of some of the interviews).

TABLE A

TYPES OF LIFE STYLE ADAPTATION:
CONVENTIONALITY VS. CRIMINALITY OF 248 ADDICTS
(Using Stringent Cutting Points between High and Low Values)

		CONVENTIONALITY	
		High **(high on 5 of 5 indexes)**	***Low*** **(high on 0–4 indexes)**
CRIMINALITY	*Low* (score 0—no criminal behavior)	Conformists 3%	Uninvolved 12%
	High (score 1 or more—at least 1 criminal item)	Two-Worlders 4%	Hustlers 81%

Even in our sample, skewed in the direction of the socially and economically depressed addicts, 47 patients, a fifth of the total, deviated in one respect or another from the stereotype when the stereotype was defined in the strictest possible way. In order to analyze the variability within each group and within the sample as a whole, and in order to obtain for this analysis sufficient cases of each of the four adaptation types, median-split cutting points were used to describe the classes.

This was done by dichotomizing the sample on conventionality and criminality into high and low groups as nearly equal in size as possible. The resulting distribution, which was arrived at using the indexes previously described, is shown below. Even with the use of median splits, the stereotype would lead us to expect a concentration of cases in the hustler and conformist cells. Instead, almost half of the cases fell into the mixed cells, showing deviation from the negative relationship expected between conventionality and criminality.

TABLE B

TYPES OF LIFE STYLE ADAPTATION: CONVENTIONALITY VS. CRIMINALITY OF 248 ADDICTS

(Using Median Split Points Between High and Low Values)

	CONVENTIONALITY	
CRIMINALITY	*High* (high on 3 + indexes)	*Low* (high on 0–2 indexes)
Low (score 0–4)	Conformists 23%	Uninvolved 21%
High (score 5–19)	Two-Worlders 25%	Hustlers 30%

Validation of Typology

In order to validate the assumption that the four types constitute a true typology in the sense that the two dimensions combine in unique ways to create four qualitatively different types of adaptation patterns rather than four different points on a unidimensional continuum, it was necessary to demonstrate that each type exhibited a distinctive pattern of behavior in a number of specific ways not originally used to establish the typology. The fact that such distinctiveness can be demonstrated, even though each group is considerably "diluted" (by the use of median split divisions rather than stringent cutting points) lends convincing evidence in support of the validity of the typology.

For each type, many measures of conventional and criminal behavior not considered in establishing the typology in the first place were compared, together with a group of measures designed to test a unique characteristic of the type: for the conformists, "conforming behavior"; for the uninvolved, "asocial behavior and utilitarian dependency"; for the two-worlders, "other orientation and straddling behavior"; and for the hustlers, "addict social system participation" (75 percent of the hustlers, for example, are highly involved with other addicts, as compared to 15 percent of the conformists, 30 percent of the uninvolved, and 54 percent of the two-worlders).

Some of the distinctive characteristics of the conformists in comparison to the other three types are given in the following four tables, as examples of the way in which the typology validation procedure was carried out.

TABLE C

CRIMINAL BEHAVIOR OF 41 CONFORMISTS COMPARED TO THAT OF THREE OTHER ADAPTATION TYPES

	Conformist	*Two-Worlder*	*Unin-volved*	*Hustler*
N=	(41)	(50)	(30)	(49)
CONFORMISTS ARE LOW IN CRIMINALITY . . .				
	percent	*percent*	*percent*	*percent*
No police offenses since addiction noted by hospital.	*63*	29	24	14
Never been in jail or reform school.	*46*	28	20	12
Knows less than 4 of 5 prison expressions queried.	*93*	82	81	67
Denies "almost getting busted" influenced hospitalization.	*80*	50	62	50

TABLE D
CONVENTIONAL BEHAVIOR OF 41 CONFORMISTS COMPARED TO THAT OF THREE OTHER ADAPTATION TYPES

	Conformist	*Two-Worlder*	*Uninvolved*	*Hustler*
N=	(41)	(50)	(30)	(49)
CONFORMISTS ARE HIGH IN CONVENTIONALITY . . .				
. . . In Work Life				
	percent	*percent*	*percent*	*percent*
Worked at least 50 percent of time since addicted.	*60*	36	38	18
Kept best-liked job over one year.	*67*	40	46	28
Held job over 1 year while using drugs.	*46*	28	28	19
Have job waiting after discharge.	*32*	16	3	—
. . . In Family				
Gives some money to (former) wife or family weekly.	*37*	23	20	25
Father helps out when patient needs it.	*34*	24	23	25
Family is close because of love or friendliness.	*24*	5	6	14
Family will help or get along with patient after discharge.	*78*	68	62	44
. . . With Friends				
Talking with someone respected helped in coming to hospital.	*76*	68	50	58
Drugs usually taken with same persons.	*78*	52	71	41
Very often associates with someone who never used drugs.	*81*	51	58	50

TABLE E
AWARENESS BY NEIGHBORS OF THE DRUG HABITS OF ADDICTS

	Conformist	*Two-Worlder*	*Uninvolved*	*Hustler*
N=	(40)	(50)	(29)	(49)
	percent	*percent*	*percent*	*percent*
Neighbors don't know about habit	63	32	27	29
Neighbors know about habit	32	66	66	71
Doesn't know if neighbors know	5	2	7	--
	100	100	100	100

TABLE F

"CONFORMING" BEHAVIOR OF 41 CONFORMISTS COMPARED TO THAT OF THREE OTHER ADAPTATION TYPES

N=	*Conformist* (41)	*Two-Worlder* (50)	*Unin-volved* (30)	*Hustler* (49)
CONFORMISTS ARE DISTINCTIVE IN THEIR "CONFORMING" BEHAVIOR				
. . . In Sharing Society's Moralistic Views and Myths				
	percent	*percent*	*percent*	*percent*
Negative attitude toward combining work and drug use.	*66*	40	43	37
Thinks it's bad idea to help addicts keep habits small enough to keep a job.	*38*	28	33	20
Thinks it's bad idea to give methadone to addicts on hospital waiting list.	*37*	16	17	20
Doesn't disagree that heroin hurts the body more than alcohol.	*78*	60	63	53
. . . In Being a "Square"				
Does not associate "easy time" with prison or drugs.	*95*	80	70	76
Has not asked a stranger for money in last 3 or 4 months.	*88*	72	70	60
Denies going without shaving for week or so during last 3 or 4 months.	*72*	49	64	56
. . . In Hiding One's Addiction				
No more than a few of family know about drug use.	*46*	33	28	19
Has not told family about drug use.	*24*	13	4	6
There is someone whom patient does not want to know about drug use.	*80*	61	48	71
Is ashamed of using drugs.	*26*	10	—	9
When takes drugs usually does so alone.	*76*	46	52	45

Psychiatric Diagnoses

The personalities of patients admitted to the narcotic wards were assessed by a staff psychiatrist and/or psychologist who made a psychiatric diagnosis. Some of the patients also received mental status examinations in which specific aspects of the personality were evaluated. The table below shows the dominant psychiatric diagnosis of the 238 patients in our sample for whom we had this information.

TABLE G

DOMINANT PSYCHIATRIC DIAGNOSIS OF 238 NARCOTIC ADDICTS ADDICTED TO METROPOLITAN HOSPITAL IN 1962-63

Diagnosis	*Percent of All Diagnoses*			*# of Cases*		
I. PERSONALITY DISORDERS			87%			206
Personality Trait Disturbance		40%			94	
Passive-aggressive personality	25%			58		
Passive-aggressive, dependent	15%			36		
Personality Pattern Disturbance		11%			25	
Inadequate personality	4%			9		
Schizoid personality	6%			13		
Paranoid personality	1%			3		
Sociopathic Personality		34%			82	
Sociopath, sociopathic personality	10%			24		
Antisocial reaction	1%			3		
Dyssocial reaction	1%			2		
Drug addiction	22%			53		
Personality Disorders, Unspecified		2%			5	
II. PSYCHOSES			13%			31
Schizophrenic Reactions		13%			30	
Paranoid schizophrenia	7%			17		
Schizophrenia, undifferentiated	5%			12		
Schizophrenic reaction, schizo-affective type	1%			1		
Other Psychotic Reactions					1	
III. PSYCHONEUROTIC DISORDERS						1
			100%			238

When psychiatric diagnoses and life style adaptations are compared, they are found to be significantly independent. While some relationships are suggested, they are small to moderate in degree and are not consistently in the directions one might expect. Since we were not able to obtain uniformly conducted psychiatric diagnoses for the entire sample, however, the present results contribute only a preliminary view of what the actual relationships between the two classification systems might be.

In order to make the most of this preliminary view, we examined the possibility that a patient's social adaptation—his conventionality and his criminality—might influence the way the diagnostician sees him and consequently the diagnosis given. We know, for example, that such a tendency obtains in the diagnosis of chronic alcohol users.

This influence may operate on diagnosis in two ways. Since social adjustment is generally congruent with personality organization, the clinician may perceptively take aspects of the former as clues to the status of the latter. Also, the clinician may at times be unwittingly diverted from an objective assessment of the personality by behavioral indices which bring into play social class values or other bases for invidious distinctions. It should be noted, in passing, that it was impossible for an addict to be diagnosed as mentally well, for by definition drug addiction is considered as a type of sociopathic personality disturbance.

TABLE H

DOMINANT PSYCHIATRIC DIAGNOSIS BY CONVENTIONALITY AND CRIMINALITY

PSYCHIATRIC DIAGNOSIS	*CONVENTIONALITY*		*CRIMINALITY*	
	Low	*High*	*Low*	*High*
	percent	*percent*	*percent*	*percent*
Drug Addiction Only	18	*28*	20	*26*
Personality Trait Disturbance	36	*46*	37	*44*
Sociopathic Personality Disturbance	*16*	7	*13*	10
Personality Pattern Disturbance	*14*	9	*15*	9
Schizophrenic Reaction	*16*	10	*15*	11
	100	100	100	100
N=	(76)	(82)	(67)	(91)

Table H suggests the directions of possible influences which adaptation variables may have on diagnosis. The patterns which emerge indicate that addicts who are classed as high on either conventionality or on criminality are somewhat more likely than addicts classed as low on these measures to receive a diagnosis of drug addiction only or of personality trait disturbance, and slightly less likely to be diagnosed as having a sociopathic personality disturbance or a personality pattern disturbance or a schizophrenic reaction.

Now the diagnoses of drug addiction and personality trait disturbances can be considered to be indicators of less severe disturbance than the diagnoses of personality pattern disturbance and schizophrenia, and the diagnosis of sociopathic personality disturbance can be considered to denote a condition of intermediate severity. Within this framework, the results lend themselves to the following hypothesis: addicts who are highly involved in activities and social relationships—be they conventional or deviant—are more likely to be seen by the examining clinician as less severely disturbed than those who are not so involved in life.

If this kind of influence were operating we would expect to find the two-worlders, who fall into both the high conventionality category and the high criminality category, to be most likely of the adaptation types to receive a milder diagnosis. Conversely, we would expect the uninvolved to be the type most likely to receive diagnoses of severe disturbances. It is clear, in fact (from Table H), that the two-worlders are the most likely type to be seen as less severely disordered (i.e., diagnosed as drug addiction or personality trait disturbance); and the uninvolved are somewhat more likely to be seen as more severely disturbed.

TABLE I

DOMINANT PSYCHIATRIC DIAGNOSIS BY TYPES OF LIFE STYLE ADAPTATION

DOMINANT PSYCHIATRIC DIAGNOSIS	*Conformist*	*Two-Worlder*	*Uninvolved*	*Hustler*
N=	(37)	(45)	(30)	(46)
	percent	*percent*	*percent*	*percent*
Relatively Less Severe	64	82	46	59
Drug Addiction Only	24	31	13	22
Personality Trait Disturbance	40	51	33	37
Relatively More Severe	36	18	54	41
Sociopathic Personality Disturbance	8	7	20	13
Personality Pattern Disturbance	14	4	17	13
Schizophrenic Reaction	14	7	17	15
	100	100	100	100

When we combine the percentages for drug addiction and personality trait disturbance, as in table I, and compare them with the percentages for the three more serious diagnoses for each adaptation type, we get the following results: 82 percent of the two-worlders are diagnosed as less severely disturbed compared to 64, 59, and 46 percent of the conformists, hustlers, and uninvolved respectively.

The same data also show that 54 percent of the uninvolved addicts were diagnosed as severely disturbed compared to 41, 36, and 18 percent of the hustlers, conformists, and two-worlders respectively.

It is, of course, possible that the addict's social adaptation does not influence the diagnosis except in the ways it should—by providing pertinent behavioral data necessary for a careful diagnosis. Little or no exception, for example, can be taken to the results for the uninvolved. Even the uninvolved themselves are most likely to feel that they have at least some psychological problem. A full two-thirds of this adaptation type say they have such a problem compared to 56, 46, and 33 percent of the hustlers, two-worlders, and conformists respectively.

The results for the two-worlders, however, are more open to question. The lack of social integration in the lives of the two-worlders in terms of their split social life does not necessarily give a strong impression of the absence of severe mental illness.

Nevertheless, it is just possible that the two-worlder adaptation is more likely than the other adaptations to be taken on by addicts who have not yet experienced serious personality disintegration. It may be the most normal reaction to the abnormal circumstances of being an addict in our society, even more normal than that of a conformist adaptation.

Some Correlates of Life Style Adaptation

Several relationships between type of adaptation and type, frequency, and amount of drugs used are notable. The uninvolved are the most likely of the groups to appear dependent on an extensive drug habit in which a heavy heroin habit is combined with regular nonopiate drug use; the two-worlders are most likely to have reported a very heavy heroin habit—seven or more $5 bags daily; the hustlers ranked a close second in each regard; and the conformists were in both cases least likely to use drugs heavily.

As previously mentioned, the typical drug user in our sample became addicted at 18 years of age, having first learned of drugs at about 16 and having first tried them at about 17 (median age of the sample was 25).

While the survey data do not tell us how our addicts adapted immediately following the onset of their addiction, our data do show associations between age of onset and later adaptation at the time of admission to Metropolitan Hospital. We should expect some relationship, since it is logical to assume that, all other things being equal, persons who become addicted early in life have had far fewer opportunities than persons addicted in later years to have established the basis for a normal, conventional life. Table J reveals a definite relationship—though, of couse, not necessarily a causal one—between adaptation type and age of onset of addiction.

TABLE J

LIFE STYLE ADAPTATION TYPES BY AGE OF ONSET OF ADDICTION

	AGE OF ONSET			
ADAPTATION TYPE	*Low (Under 17)*	*Medium Low (17, 18)*	*Medium High (19–21)*	(22 +)
	percent	*percent*	*percent*	*percent*
Conformist	18	15	24	40
Two-Worlder	39	26	24	27
Uninvolved	16	21	17	17
Hustler	27	38	35	16
	100	100	100	100
N=	(51)	(39)	(34)	(45)

The lowest age of onset group, which includes those addicted under 17 years of age, is more likely than the higher age of onset groups to include two-worlders. Thirty-nine percent of the low group compared to 26, 24, and 27 percent of the other groups are two-worlders. The medium low onset group, addicted at 17 and 18 years of age, is the most likely of the groups to include hustlers (38 percent compared to 35, 27, and 16 percent) and the least likely to include conformists. The medium high group, addicted at 19 through 21 years of age, is second most likely to include hustlers. The high onset group, consisting of those addicted at 22 years of age or older, is more likely than the younger onset groups to include conformists and least likely to include hustlers. The uninvolved are rather evenly distributed among the groups.

Since adaptation is a developmental concept implying changing behavior in response to changing circumstances, it should be enlightening to analyze adaptation in relation to the stage of addiction at which the person adapting finds himself. The most convenient measure we have of stage of addiction, outside of social adaptation itself, is length of addiction.

We have noted that length of addiction was positively related to type, frequency, and amount of drug use. This, together with the popular notion that addiction is progressive in its deteriorating effects on social adaptation, would lead one to believe that adaptation would change for the worse (i.e., become less conventional and/or more criminal) the longer a person was addicted.

Such broad generalizations, however, do not fit the facts in crucial respects. As table K suggests, both highly criminal groups—the two-worlders and the hustlers—appear to increase in their rate of occurrence as the length of addiction increases from low (no more than 2 years) to medium high (from over 5 years through 9 years), but to decrease after about 9 years of addic-

TABLE K

LIFE STYLE ADAPTATION TYPES BY LENGTH OF ADDICTION

ADAPTATION TYPE	*LENGTH OF ADDICTION* *Low (Up to 2 years)*	*Medium Low (2+ to 5 years)*	*Medium High (5+ to 9 years)*	*High (Over 9 years)*
	percent	*percent*	*percent*	*percent*
Conformist	34	29	11	24
Two-Worlder	23	32	39	24
Uninvolved	20	9	17	25
Hustler	23	30	33	27
	100	100	100	100
N=	(30)	(53)	(36)	(51)

tion. Concomitantly, both the conformists and the uninvolved, types which share low criminality in common, decrease their rate of occurrence as length of addiction increases from low to medium low or medium high, and then increase as addiction moves to the high category from one or another of the medium categories.

As for general trends, data derived from these results by combining percentages for appropriate pairs of adaptation types show that: conventionality appears to decrease after 5 years of addiction, but not after 9 years; and criminality increases among the length of addiction categories from low to medium high, but then decreases after 9 years. (Percentages for high conventionality addicts within each length of addiction category can be derived from the figures in table K by adding the percentages for conformist and two-worlder adaptations. Similarly, by combining the two-worlder and hustler percentages, we can derive the percentage of highly criminal addicts found within each duration category.)

If the stereotype of the progressively deteriorating drug addict implies that he continues to withdraw further from the conventional world and to enter more deeply into the criminal world the longer he is addicted, these findings force us to reject the stereotype. Instead, we find it likely that increasing duration of addiction may result in an initial movement toward lower conventionality and higher criminality followed by antistereotypic patterns of two types. These consist of a levelling out in the proportion of conventional addicts and an actual decrease in the proportion of highly criminal addicts.

More specifically, table K shows that the conformists are most likely to appear among those in our sample who have been addicted no more than two years. The low point of their occurrence, however, is associated with a medium high duration of addiction rather than a high duration.

TABLE L

LIFE STYLE ADAPTATION TYPES BY MAJOR RACIAL AND ETHNIC GROUP

ADAPTATION TYPE	*RACIAL AND ETHNIC GROUP*		
	White	*Negro*	*Puerto Rican**
	percent	*percent*	*percent*
Conformist	10	32	26
Two-Worlder	30	31	28
Uninvolved	23	17	16
Hustler	37	20	30
	100	100	100
N=	(40)	(59)	(70)

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*This category includes 3 individuals with Spanish speaking backgrounds other than Puerto Rican.

The conformists in our sample are not, as some might expect, largely whites. As table L shows, whites are, in fact, least likely of the major racial and ethnic groups to be conformists. Instead, they are most likely of the groups to be uninvolved and to be hustlers. This means that whites are least likely to be conventional and most likely to be criminal.

The Negroes in our sample tended to adapt in just the reverse fashion. They are more likely than the whites and Puerto Ricans to score high in conventionality and least likely to score high on criminality. Specifically, the Negroes are the most likely of the groups to be conformist in adaptation and least likely to be hustlers.

The Puerto Ricans ranked intermediate between the extreme positions of whites and Negroes on both conventionality and criminality.

How do we account for the fact, derived from table L, that 62 percent of the Negroes were highly conventional compared to only 40 percent of the whites, while two-thirds of the whites were highly criminal compared to only half of the Negroes? These general differences are specifically exemplified by the association of whites with the hustler and uninvolved adaptations and in the association between the Negro and the conformist adaptation.

A possible explanation is provided by the notion that, in a dominantly white society, deviant behavior like addiction and crime causes less of a disruption for discriminated against minorities than for majority groups, in maintaining whatever degree of conventionality while deviating in serious fashion from other norms of acceptable behavior. A member of the dominant white group who deviates in similar fashion, however, finds less community sympathy and support and is therefore more likely than the Negro deviant to be isolated from conventional areas of living.

The slightly greater likelihood of whites than of the other groups to be uninvolved also suggests the possibility that when a member of the white majority becomes an addict, he is more likely than a Negro minority group member to be either psychologically or socially disordered. In some cases, such disturbances might show themselves in a withdrawal from social involvement generally, the hallmark of the uninvolved.

The Hospital

Since application for admission to Metropolitan's drug wards is by and large a voluntary action taken by the individual patient, we were interested in identifying sources of pressures which may influence the individual to seek hospitalization.

In view of the many kinds of pressures from conventional life and from drug life which may combine to influence an addict to go to the hospital, it is understandable that many patients may unintentionally give oversimplified or inaccurate reasons for going, out of ignorance of the complex and real influences on them working in combination or out of a reasonable desire to conceal potentially self-incriminating aspects of their lives. In viewing responses to direct questions about motives or goals in going to a hospital, then, we are well advised to consider them with care.

As a first step in getting close to the real motives, we analyzed the addicts' statements about what they wanted the hospital to do for them.

TABLE M

DOMINANT RESPONSE OF ADDICTS REGARDING WHAT THEY WANT HOSPITAL TO DO FOR THEM, BY TYPES OF LIFE STYLE ADAPTATION

DOMINANT RESPONSE OF WHAT ADDICTS WANT HOSPITAL TO DO N=	*Conformist* (41)	*Two-Worlder* (50)	*Uninvolved* (30)	*Hustler* (49)
	percent	*percent*	*percent*	*percent*
. . . *Drug Oriented Change*	78	76	*90*	80
Break habit, help kick, cure me	76	66	70	74
Withdrawal only	2	10	*20*	6
. . . *Nondrug Oriented Change*	15	*22*	6	14
Change way of life	5	8	3	8
Psychiatric change	10	14	3	6
. . . *Other*	7	2	4	6
	100	100	100	100

We were able to break down the blanket category of "break the habit, help me kick, or cure me" into two major groups: those who wanted to "get off" drugs and those who wanted to "stay off" drugs as a result of the hospital's efforts. Getting off is used here as a crude index of the addict's definition of "cure" and staying off as a crude index of staff's definition of "cure."

TABLE N

SPECIFIC OBJECTIVES OF DRUG-ORIENTED CHANGE, BY TYPES OF LIFE STYLE ADAPTATION

SPECIFIC OBJECTIVE N=	*Conformist* (35)	*Two-Worlder* (41)	*Uninvolved* (26)	*Hustler* (42)
	percent	*percent*	*percent*	*percent*
Get off drugs	80	81	81	67
Stay off drugs	20	19	19	33
	100	100	100	100

A more elaborate attempt to measure real addict motivation for hospitalization was made by measuring the consistency with which our patients referred to one or more goals of hospitalization throughout the phases of interviewing. We constructed indexes of goal consistency for stay-off goals, social change goals, and psychiatric goals, following the same procedure with each index of comparing responses to various questions in which the patient had a reasonable opportunity to state goals. Combining the three separate indexes of goal consistency into one composite index of consistency of goal orientation, we classified each addict simultaneously on whether he scored high or low on his consistency with regard to each goal. Table O indicates the consistency with which various combinations of goals were referred to by each adaptation type. This summary throws serious doubt on the existence of strongly held change goals for the majority of our sample.

TABLE O

GOAL REFERENCE CONSISTENCY, BY TYPE OF LIFE STYLE ADAPTATION

CONSISTENCY OF REFERENCES TO GOALS OF HOSPITALIZATION N=	*Conformist* (41)	*Two-Worlder* (50)	*Uninvolved* (30)	*Hustler* (49)
	percent	*percent*	*percent*	*percent*
High Stay Off Drugs Only	4	4	7	6
High Social Change Only	—	8	3	6
High Psychiatric Change Only	—	10	7	14
High Stay Off and Social Change	—	—	—	—
High Stay Off and Psychiatric Change	3	—	3	6
High Social and Psychiatric Change	3	—	—	—
Nonchange Goals (e.g., get off only)	90	78	80	68
	100	100	100	100

Of the 170 cases analyzed, 133 or 78 percent scored low on all three change goals. These are the addicts for whom nonchange goals (e.g., haven, shelter, rest) or short-term change goals (e.g., reduction of habit, physical rehabilitation) are apparently the dominant motives for hospitalization.

By the same token, 22 percent of the addicts in our sample consistently professed a desire to use the hospital to change their lives in one or more of the ways indicated. Compared to other kinds of patients in a hospital, a desire for change on the part of a fifth of our sample of patients seems low indeed. But to those who see *all* addicts as concerned only with maintaining their habits and nothing more, this figure must conversely seem large.

In their expectations, the adaptation types enter the hospital with different orientations. When asked what they think the hospital is trying to do, the patterns of response correspond to those shown earlier in answer to the question about what they want the hospital to do for them.

TABLE P

DOMINANT RESPONSE OF ADDICTS TO WHAT THEY THINK HOSPITAL IS TRYING TO DO, BY TYPES OF LIFE STYLE ADAPTATION

DOMINANT RESPONSE TO WHAT ADDICTS THINK HOSPITAL IS TRYING TO DO . . . N=	*Conformist* (41)	*Two-Worlder* (50)	*Uninvolved* (30)	*Hustler* (49)
	percent	*percent*	*percent*	*percent*
. . . *Drug Oriented Goal*	37	37	50	41
Break drug habit, help addicts kick, get cured	37	37	47	35
Withdrawal only	—	—	3	6
. . . *Nondrug Oriented Goal*	36	45	20	26
Change way of life	12	25	10	8
Psychiatric change	5	—	—	6
Help addicts (unspecified)	19	20	10	12
. . . *Other*	27	18	30	33
Solve social problem of addiction	15	10	23	17
Research	7	4	7	12
Other; don't know	5	4	—	4
	100	100	100	100

The patients' perceptions regarding what the hospital is trying to do and their general statements of goals ("break the habit, help kick, cure me") also correspond to staff attitudes and orientation. A relatively high consensus as to the specific nature of the treatment aim of the program was found among staff. About three-quarters of the sample believed that staying off drugs is the most important thing for an addict when he leaves the hospital. Although less than the proportion of the patients who also agreed with this goal, this finding confirms that abstinence rather than rehabilitation has remained the implicit goal of treatment.

An equally high degree of consensus exists among the staff studied with respect to seeing addicts as sick people. All but one saw them as sick, and 76 percent specified their sickness to be mental or emotional.

It would appear that the preoccupation with abstinence on the part of staff results in no small degree from the effects of the cultural judgement that drug addiction—sickness or not—is an expression of immorality. Otherwise, the sheer removal of a psychiatric symptom or the remission of a chronic condition for which there is no known cure would not take on such importance in a medical program.

Preliminary evidence in support of this hypothesis is directly provided by the following finding: while none of the 12 staff members who felt that drug use was immoral disagreed with the notion that abstinence was the most important thing for an addict, as many as 11 of 21 who saw *no* immorality in drug use denied that abstinence was the most important thing.

The contradictory diagnosis of a drug addict as someone who is both sick and immoral is indeed made by about 33 percent of those interviewed. Although no doubt smaller than the proportion of the general population who hold such an ambivalent view, this figure appears to be a high one for a psychiatrically directed staff. The point here is not that such a belief is right or wrong, but that it reflects the cultural ambivalence of the larger society in singling out the use of narcotic drugs for extreme moral censure while at the same time viewing it as a sickness.

After Discharge

When we asked whether the hospital had done them any good, 75 percent of the patients answered in the affirmative and 25 percent in the negative. These results provide data from another perspective in support of the proposition that addicts measure their success in terms of detoxification or reduction of habit rather than in terms of abstinence, for more than half of the self-defined successful patients were back on drugs at the time of their answer.

Although most of the discharged patients later saw themselves as successful in having gotten help from the hospital, these successes, as well as the failures, nevertheless felt they had post-hospital problems. Half of the total sample first mentioned a drug oriented problem. Just over a quarter of the total group specified the problem as using drugs, while 14 percent pointed to staying away from drugs or situations conducive to drug use. The remaining 10 percent of drug responses referred to concerns over health, rehospitalization, and money for drugs.

TABLE Q

RATES OF SUCCESS IN ACHIEVING ALTERNATIVE DRUG STATUS GOALS THROUGH HOSPITALIZATION BY TYPES OF LIFE STYLE ADAPTATION

Success Rates for 166 Cases	*ALTERNATIVE GOALS WITH CRITERIA OF SUCCESS FOR EACH*	*SUCCESS RATES IN TERMS OF PERCENT OF EACH ADAPTATION TYPE MEETING GIVEN CRITERION OF SUCCESS*			
		Conformist N = (41)	*Two-Worlder* (49)	*Uninvolved* (28)	*Hustler* (48)
percent		*percent*	*percent*	*percent*	*percent*
88	*Reduction of Habit* (via staying in hospital 7 days or more).	90	88	90	84
64	*Detoxification* (via staying in hospital 2 weeks or more).	63	64	66	60
46	*Self-Evaluation that Hospital Has Done Good* (via reduction of habit, detoxification, or painless withdrawal reported on followup).	68	39	41	40
24	*Abstinence* (via reported nonuse of drugs at time of followup interview).	49	22	18	8

Table Q lists four drug status goals together with the criterion used in measuring success in achieving each, in the second column from the left. The first column shows the success rates achieved by a subsample of 166 cases for each of the goals. The criteria are listed in the order of their achievement by the 166 life style analysis cases.

Eighty-eight percent of this subsample were successful in meeting the criterion of habit reduction by staying in the hospital at least 7 days; detoxification was accomplished, by our definition, by 64 percent; 46 percent of the cases judged themselves to have been successful in getting some good out of the hospital in terms of either detoxification or habit reduction; finally, 24 percent of this special subsample were successfully abstinent at the time of their followup interview.

Indexes of conventionality after discharge and criminality after discharge were constructed using data from followup interviews. We then cross tabulated our two composite indexes in order to classify each addict simultaneously on conventionality and criminality. The resulting four-fold table gave us our four familiar life style adaptation types. The distribution of patients among the types, however, revealed a much stronger negative relationship between criminality and conventionality than obtained at the time of admission.

Since the two separate dimensions of conventionality and criminality after discharge were each dichotomized into nearly equal halves of 51 and 49 percent each, we would expect to find 25 percent of the total sample falling into each adaptational type if no relationship existed between these two variables. Instead, we find 32 percent falling into each of the conformist and hustler categories. The remaining 36 percent of the sample divided equally into the two-worlder and uninvolved types, with 18 percent in each of these mixed categories.

For some reason, high conventionality is more likely to be associated with low criminality, and low conventionality is more likely to be associated with high criminality, after discharge than just prior to admission.

The differences between the responses of this subsample to identical questions on conventionality asked both before and after discharge were relatively small but revealed a tendency toward slightly more conventional involvement before admission than after discharge. On the crucial varitble of work, however, there was no apparent difference between the two time periods—approximately 45 percent at each point had worked within the recent past.

Although our data on criminality are not based on identical questions, we feel reasonably secure in comparing our before and after measures, at least in terms of the sheer existence or absence of recent criminal involvement. The differences are the most striking we have found between before and after responses. While 18 percent of the group reported no recent criminal activity at the time of their admission, as many as 45 percent were judged by our qualitative coders to be uninvolved in such activities at the time of their followup.

Other data and information suggest that the drop in criminal involvement is reflective of real behavior changes and not just an artifact of our methodology. We know that just prior to admission when our subsample was more likely than after being discharged to report a high degree of criminal activity, virtually all were using drugs and under financial pressures to get money or drugs illegally. It is logical to expect that this group would be less involved in crime shortly after discharge, if only because a fifth were not using drugs.

It is apparent from table R below that more discharged patients, including those who are using drugs again, are classified as improved than as deteriorated. While about a third of the two drug groups combined maintained a constant level of criminal involvement, the remaining two-thirds who changed were more than twice as likely to show improvement by decreasing their criminal activities (48 percent) than they were to deteriorate into increased crime (20 percent).

TABLE R

NATURE OF CHANGE IN CRIMINAL ACTIVITY BETWEEN PREADMISSION AND POSTDISCHARGE BEHAVIOR, BY DRUG STATUS AFTER DISCHARGE

	DRUG STATUS AFTER DISCHARGE	
NATURE OF CHANGE IN CRIMINALITY	*Not Using Drugs*	*Using Drugs*
	percent	*percent*
Improved (decreased)	69	42
Constant	31	31
Deteriorated (increased)	—	27
	100	100
N=	(39)	(123)

The fact that this improvement holds for the relapsed group as well as for the nonusing group has important implications. It suggests that the goals of habit reduction and detoxification can each lead to an improved social adaptation for addicts in terms of lowered criminal involvement and can reduce at least temporarily the number of crimes perpetrated against the community to buy drugs for big habits.

Our evidence consistently shows that addicts tend, with the help of the hospital, to become less criminal for a while, even if they are not "cured." Though this kind of help may be inadvertent on the part of the hospital, it may be part of an interrelated set of goals which the patient has in going to the hospital. Such a set is likely to include reduction of a large habit, reduction of heavy criminal involvement, and improvement of physical health.

Data referred to earlier, based on pre- and post-hospital responses to identical questions, suggested that conventionality appeared slightly higher before hospitalization than afterwards. We can further assess the progress or lack of it in achieving a more conventional life after discharge by comparing our findings for conventionality with those for criminality regarding changes since hospitalization.

For this purpose, we cross tabulated our index of conventionality at time of admission against the index of conventionality after discharge and compared the results with those obtained by cross tabulating before and after indexes of criminality against each other. The two sets of findings are juxtaposed in table S below.

In order to make the data for criminality as comparable as possible to that on conventionality, we used the composite indexes of each at time of admission, rather than using the recent criminal acts index. As the table shows, however, the patients are still more than twice as likely to improve than to deteriorate in criminality.

TABLE S

COMPARISON OF CHANGES IN CONVENTIONALITY AND CRIMINALITY BETWEEN PREADMISSION AND POSTDISCHARGE BEHAVIOR

NATURE OF CHANGE	*ADAPTATIONAL BEHAVIOR*	
	Conventionality	*Criminality*
	percent	*percent*
Improved	28	44
Constant	36	40
Deteriorated	36	16
	100	100
	N=(166)	(166)

This is in contrast to the behavior of the same group on conventional involvement. The patients are actually more likely to deteriorate than to improve on conventionality, 36 to 28 percent respectively. One of the identical questions asked of patients at both time periods probed their recent participation in 10 leisure time activities. Here also, more patients shifted from a high score to a low score than vice versa.

It would appear, then, that the hospital program does not serve as effectively as rehabilitative agency in the sense of a "conventionalizing" facility as it serves as a detoxifying and "decriminalizing" agency.

APPENDIX E

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